DOCUMENT RESUME

ED 461 085	CG 031 522
AUTHOR	Brock, Stephen E., Ed.; Lazarus, Philip J., Jr., Ed.; Jimerson, Shane R., Ed.
TITLE	Best Practices in School Crisis Prevention and Intervention.
INSTITUTION	National Association of School Psychologists, Bethesda, MD.
ISBN	ISBN-0-932955-84-3
PUB DATE	2002-00-00
NOTE	807p.
AVAILABLE FROM	National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814. Tel: 301-657-0270; Fax: 301-657-0275; Web site: http://www.naspweb.org.
PUB TYPE	Books (010) -- Collected Works - General (020) -- Guides - Non-Classroom (055)
EDRS PRICE	EDRS Price MF05 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Comprehensive Programs; Counselor Training; *Crisis Intervention; Elementary Secondary Education; Integrated Services; Intervention; Posttraumatic Stress Disorder; Prevention; *School Counseling; *School Counselors
IDENTIFIERS	Loss; Traumas

ABSTRACT

This publication on best practices in crisis prevention and intervention is divided among the concepts of primary, secondary, and tertiary prevention. The introductory chapter examines crisis theory and establishes a foundation for the comprehensive crisis prevention and intervention team. It also attempts to bridge the gap between theory and crisis intervention. Section 2, "Primary Prevention: Preventing and Preparing for Crisis Events," presents chapters that address preventing and preparing for crises. Sections 3, "Secondary Prevention: The Immediate Response to Crisis Events," and 4, "Secondary Prevention: Responding to Specific Crises," present chapters containing information that can be useful when responding to crises. Section 5, "Tertiary Prevention: Long-Term Treatment of Traumatized Individuals," offers a review of long-term rehabilitation issues associated with crisis, trauma, and loss. Although the activities described in Section 5 may be beyond the scope of the school-based crisis team, the information is included to explain how long-term treatment may be warranted with posttraumatic stress disorders. The chapters in Section 6, "Special Issues in Crisis Prevention and Response," look at additional issues crucial for the response to a crisis. Chapters are included on crisis prevention and the legal and ethical issues. Ideas for future research are also presented. (Contains 5 appendixes, 19 figures, 40 tables, and over 1,000 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 461 085

Best Practices IN School Crisis Prevention AND Intervention

Edited by
Stephen E. Brock, Ph.D., NCSP
Philip J. Lazarus, Ph.D., NCSP
Shane R. Jimerson, Ph.D., NCSP

CG031522

NASP

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
S. GORIN
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
2B

BEST COPY AVAILABLE

Best Practices IN School Crisis Prevention AND Intervention

Edited by
Stephen E. Brock, Ph.D., NCSP
Philip J. Lazarus, Ph.D., NCSP
Shane R. Jimerson, Ph.D., NCSP

NASP
National
Association of
School
Psychologists

The cover and text were designed by Octavo Designs. Together, the two characters on the cover and throughout the work represent the Chinese word for crisis. The two characters are "wei," which means danger, and "ji," which means opportunity. Wei describes the crisis and ji predicts its potential. This symbol has also been described as opportunity blowing upon an ill wind. This way of viewing crises is consistent with the theme of our book. A major goal of this volume is to help schools turn crises into growth producing opportunities and make our schools safer and more responsive. Published by the National Association of School Psychologists

---

Mailing addresses, e-mail addresses, phone numbers and websites were current at the time of publication of this book. This information is provided as a service to our readers. Neither the chapter authors, editors nor NASP endorses all the material contained in the websites or provided by listed agencies or organizations. Over time all information can change. Nonetheless, we hope you will find the information provided useful.

From the NASP Publications Board Operations Manual

The content of this document reflects the ideas and positions of the authors. The responsibility lies solely with the authors and does not necessarily reflect the position or ideas of the National Association of School Psychologists.

Copyright © 2002 by the National Association of School Psychologists.

All rights reserved. Except for a reviewer who wishes to quote brief excerpts in connection with a review in a magazine or newspaper, and as permitted under the United States Copyright Act of 1976, no part of this publication may be reproduced or distributed in any form or by any means, electronic, mechanical, photocopying, recording, scanning, or otherwise, or stored in a database or retrieval system, without the prior written permission of the publisher, or authorization through payment of the appropriate per-copy fee to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400, fax (978) 750-4474. Requests to the Publisher for permission should be addressed to Copyright Permissions, National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814, (301) 657-0270, fax (301) 657-0275, e-mail: *publications@naspweb.org*

Copies may be ordered from:
NASP Publications
4340 East West Highway, Suite 402
Bethesda, MD 20814
(301) 657-0270
(301) 657-0275, fax
e-mail: *publications@naspweb.org*
www.nasponline.org

ISBN 0-932955-84-3

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

Dedicated to

Christine Brock
Jane Lazarus
Morris and Charlotte Lazarus
Kathryn O'Brien

and to all crisis victims, survivors, their families and friends as well as all the unsung heroes who offered help in the aftermath. Know that your tears and pain have not been in vain. We have listened to you and have remembered the valuable lessons you taught us. We hope that the material contained within this volume will help prevent future tragedies and will help minimize the suffering of those who will sadly follow in your footsteps.

SEB, PJL, SRJ

Table of Contents

危
機

Foreword xi
Brian W. Flynn, United States Public Health Service

Preface xv
Scott Poland, Cypress-Fairbanks Independent School District (Houston, TX)
Susan Gorin, National Association of School Psychologists

Section 1 1
Introduction: From Theory to Practice

Chapter 1 5
Crisis Theory: A Foundation for the Comprehensive Crisis Prevention and Intervention Team
Stephen E. Brock, California State University, Sacramento

Section 2 19
Primary Prevention: Preventing and Preparing for Crisis Events

Chapter 2 23
Enabling Prevention Through Planning
Kevin P. Dwyer, National Mental Health Association
Shane R. Jimerson, University of California, Santa Barbara

Chapter 3 47
Promoting School Safety
Ronald Stephens, National School Safety Center

Chapter 4 67
Creating Nurturing Classroom Environments:
Fostering Hope and Resilience as an Antidote to Violence
Robert B. Brooks, Harvard Medical School and McLean Hospital

Chapter 5 95
Administrative Considerations in Preventing and Responding to Crisis: A Risk Management Approach
Ted Feinberg, National Association of School Psychologists
Susan Jacob, Central Michigan University

Chapter 6 109
Problem-Solving Training as a Form of Crisis Prevention
Bonnie Aberson, Miami-Dade County Public Schools
Myrna B. Shure, MCP Hahnemann University

Chapter 7 131
The Prevention of School Violence
Michael J. Furlong, University of California, Santa Barbara
Renee Pavelski, University of California, Santa Barbara
Jill Saxton, University of California, Santa Barbara

Chapter 8 151
Promoting Social Skills and Development of Socially Supportive Learning Environments
Stephen Elliott, Wisconsin Center for Education Research and University of Wisconsin-Madison
Brian C. McKevitt, University of Wisconsin-Madison
James Clyde DiPerna, Lehigh University

Chapter 9 171
Bullying in Schools: A Review of Prevention Programs
Carla Garrity, Neuro Developmental Center (Denver, CO)
Kathryn Jens, Cherry Creek School District (Englewood, CO)
William Porter, Cherry Creek School District (Englewood, CO)
Sally Stoker, Steering Committee, Bully-Proofing Your School (Denver, CO)

Chapter 10....191
Peer Mediation and Conflict Resolution
Robert D. Myrick, University of Florida

Chapter 11....211
Suicide Prevention in Schools
John Kalafat, Graduate School of Applied and Professional Psychology, Rutgers University
Philip J. Lazarus, Florida International University

Chapter 12....225
Aggression Replacement Training
Arnold P. Goldstein, Syracuse University
Barry Glick, G & C Consultants, LLC (Albany, NY)

Chapter 13 249
Identifying Troubled Youth
Sharon Lewis, Lodi Unified School District (Lodi, CA)
Stephen E. Brock, California State University, Sacramento
Philip J. Lazarus, Florida International University

Chapter 14 273
School Crisis Preparedness
Stephen E. Brock, California State University, Sacramento
Scott Poland, Cypress-Fairbanks Independent School District (Houston, Texas)

Section 3 289
Secondary Prevention: The Immediate Response to Crisis Events

Chapter 15 293
Cultural Considerations in Crisis Intervention
Jonathan Sandoval, University of California, Davis
Sharon Lewis, Lodi Unified School District (Lodi, CA)

Chapter 16 309
Developmental Aspects of Psychological Trauma and Grief
William Pfohl, Western Kentucky University
Shane R. Jimerson, University of California, Santa Barbara
Philip J. Lazarus, Florida International University

Chapter 17 333
The Community Crisis Response Team: The National Organization for Victim Assistance Protocol
Marlene A. Young, National Organization for Victim Assistance

Chapter 18 355
Estimating the Appropriate Crisis Response
Stephen E. Brock, California State University, Sacramento

Chapter 19 367
Identifying Individuals at Risk for Psychological Trauma
Stephen E. Brock. California State University, Sacramento

Chapter 20 385
Group Crisis Intervention
Stephen E. Brock, California State University, Sacramento

Chapter 21 405
Individual Crisis Intervention
Kathleen Nader, Two Suns (Cedar Park, TX)
Paulette Muni, Private Practice (Goshen, NY)

Section 4 429
Secondary Prevention: Responding to Specific Crises

Chapter 22 433
Natural Disasters
Philip J. Lazarus, Florida International University
Shane R. Jimerson, University of California, Santa Barbara
Stephen E. Brock, California State University, Sacramento

Chapter 23 449
Responding to a Sudden, Unexpected Death at School: Chance Favors the Prepared Professional
Shane R. Jimerson, University of California, Santa Barbara
Leland C. Huff, Huntington Beach Union High School District (Huntington Beach, CA)

Chapter 24 487
School Violence
Michael B. Brown, East Carolina University

Chapter 25 503
Child Maltreatment
Linda Webster, University of the Pacific
Jody Browning, University of the Pacific

Chapter 26 531
Suicide Intervention
Richard Lieberman, Los Angeles Unified School District
John Davis, California State University, Hayward

Chapter 27 553
School Suicide Postvention
Stephen E. Brock, California State University, Sacramento

Chapter 28 577
School and War
Avigdor Klingman, University of Haifa, Israel

Chapter 29 599
Traumatized Refugee Children
Patricia del Valle, Florida International University

Section 5 615
Tertiary Prevention: Long-Term Treatment of Traumatized Individuals

Chapter 30 619
Diagnosing Child-Adolescent Posttraumatic Stress Disorder
Philip A. Saigh, City University of New York
Anastasia E. Yasik, Pace University

Chapter 31 639
The Cognitive-Behavioral Treatment of PTSD in Children and Adolescents
Philip A. Saigh, City University of New York

Chapter 32 653
Children's Grief
Alan D. Wolfelt, Center for Loss and Life Transition (Fort Collins, CO)

Chapter 33 675
Innovative Treatment Methods for Psychological Trauma
Kathleen Nader, Two Suns (Cedar Park, TX)

Section 6 705
Special Issues in Crisis Prevention and Response

Chapter 34 709
Legal and Ethical Issues in Crisis Prevention and Response in Schools
Susan Jacob, Central Michigan University
Ted Feinberg, National Association of School Psychologists

Chapter 35 733
Advocating for Crisis Prevention and Intervention
Libby Kuffner Nealis, National Association of School Psychologists

Chapter 36 755
Research Needs for School Crisis Prevention Programs
Michael P. Bates, University of California, Santa Barbara
Michael J. Furlong, University of California, Santa Barbara
Jill D. Saxton, University of California, Santa Barbara
Renee Pavelski, University of California, Santa Barbara

Chapter 37 771
Research and Evaluation Directions in Crisis Intervention
Pauline Pagliocca, University of South Carolina
Amanda B. Nickerson, University of South Carolina
Stephanie H. Williams, University of South Carolina

Afterword 791
Opportunity Blowing on an Ill Wind
Philip J. Lazarus, Florida International University
Shane R. Jimerson, University of California, Santa Barbara

Foreword

危
機

RADM Brian W. Flynn
Assistant Surgeon General
United States Public Health Service

My career has afforded numerous opportunities and experiences that I could have never anticipated at its start. Some of the most unexpected as well as professionally and personally challenging experiences have had the most profound effect. Two in particular come to mind—my work following the bombing in Oklahoma City and my visit with Vice President and Mrs. Gore following the shooting at Columbine High School to meet with the families of those killed and injured. What I learned from those experiences probably could and should, in themselves, fill a book. I emerged from both those experiences with what seems to me a profound, yet simple, existential realization that should already have been obvious. I realized that there is no way one can make oneself *absolutely safe*. In the shadow of those experiences, it was frightening to be reminded of our vulnerability. The victims in these events were doing what our society tells us are the right things to do. They were going to work, they were going to school, they were providing for their families, they were preparing for their future. Yet, in a matter of moments, their lives were over or completely and tragically changed.

If one stops there, and becomes arrested by that disturbing reality, there seems to be little hope. Believing that the loss of hope is the closest we come to death in life, I found myself searching for reasons to hope.

In reality, these reasons are everywhere. Among the most powerful is the realization that, even without the ability to make our own lives and the lives of those around us completely safe, we can make our world *safer*. For me, that becomes not only a comforting realization, but also a powerful personal and professional motivator. Following those events, much of my professional energy has been spent in rededication to developing, nurturing, and implementing activities that make us, our children, and our communities safer—whether the risk is school and community violence, self-directed violence in the form of suicide, natural disasters, or terrorism. In that process, I have had the privilege to associate with many of the authors and editors of this book.

In my view, one of the most significant contributions of this book is its ability to give us powerful and pragmatic tools with which to make the world safer for our children and for those who devote their lives to our children's education and development. The fundamental message of this book is one of both hope and help.

As I reviewed the content of this ambitious text, I was struck by the breadth of the subject matter, the effective blend of theory and practical application, and the magnitude of world-class expertise reflected in its pages. At the same time, it is even more. I found myself wondering if the writers and editors realized that, in addition to making this already significant contribution, they were communicating the message that this world *can* be made safer and that there is hope for preventing and reducing suffering in a world where suffering seems so consistently and sometimes almost randomly inflicted. What a profound contribution!

The publication of this book could not be more timely. In fact, I wonder if such a book could have even been written before now. It seems to me that this book emerges at the temporal confluence of many powerful forces of science, experience, public policy, professional maturation, and social will. The science has evolved to such an extent that there is now a strong evidence base upon which to build our programs and strategies. Recent *Surgeon General's Reports on Mental Health*, on *Youth Violence*, and his *Call to Action and National Strategy on Suicide Prevention* have brought worldwide attention to these issues and clearly demonstrate the value of research and effective programming. In nearly all cases the base of our scientific knowledge is incomplete. At the same time, we have made remarkable progress in the past decade. In my view, some of our most significant challenges remain in the area of solid intervention research.

We, unfortunately, have had all too many opportunities to learn the hard lessons of experience. While schools remain among the safest places for our children, the very visible and dramatic school shootings in recent years have galvanized the country's interest and attention. We have also learned much from these tragic incidents about the factors that preceded them, how to prevent them, and how to facilitate healing in their aftermath. Governmental programs during the past several years have demonstrated the value of joining and coordinating mental health, education enhancement and reform, and security in schools. The relatively recent emergence of federal government programs that model the types of collaboration needed in local communities has been unique in my 30-plus years of federal service.

The fields of health, mental health treatment and prevention, education, and law enforcement have matured to a point where professionals in these fields have new and innovative models of collaboration that are rapidly replacing competition and guild rivalries. While I suspect professional rivalries will always exist, I sense a widening and deepening realization that no one group can solve complex problems alone. Standing alone, our skills are too narrow and our numbers are too small. Together, there is hope.

A growing social will demands that we bring together all these forces in the service of preventing crises, reducing their adverse impacts when they do occur, and ensuring the availability of high-quality treatment and intervention services when they are needed. There seems to be growing intolerance for accepting the gap between our perceived national identity as strong and compassionate problem solvers and the pain and danger in which so many of our young people find themselves. In addition, there is a growing acknowledgment that, while significant attention is being paid to individuals and communities in crisis, there remain many poor and minority communities in this nation where personal risk and vulnerability have been a long-standing legacy.

Among my most powerful memories and images of my meeting with the families of those killed at Columbine High School were pleas by several of the family members of those killed. Words did not come easily to any of us on that day. The loss was too great, the pain too deep. The only words several were able to say to me were, "Please, don't let them forget." In the moment of the greatest loss imaginable, in the moment of most unfiltered pain, they wanted the deaths of their children to have meaning.

Even without hearing the words of those families, the authors and editors of this book have honored that plea. By providing a comprehensive and well-grounded volume, they have provided a usable road map to avoid crises, to manage them appropriately when they do occur, to minimize the psychological pain, and to provide the most effective and humane care possible when the worst does occur.

In so doing they have advanced the field, they have helped give meaning to the losses of those who have already suffered, and they have given hope to us all for a safer world.

Preface

危機

Scott Poland, Ed.D.
Cypress-Fairbanks Independent School District (Houston TX)

Susan Gorin, CAE
National Association of School Psychologists

Our nation is searching for ways to prevent school violence, youth suicide, and the senseless accidental deaths that take the lives of thousands of children each year. The recently released annual report of deaths of children 17 and younger in Houston, Texas, offered these statistics: 100 died in automobile or bicycle accidents, 84 were the victims of homicide, 35 drowned, and 31 died by suicide. It is important to stress that, of these deaths, only one of the 84 homicides occurred on school grounds. Although one death is too many, schools still remain the safest places that children go! Nevertheless, it must be acknowledged that young people are dying in near record numbers in America. Each day approximately 10 children die as a result of violence in the United States. Unfortunately, most adults seem to be unaware of this staggering number. Consequently, few local, state, or national initiatives have been developed to address this problem.

A major focus of the National Association of School Psychologists (NASP) is preventing tragic deaths of children. Special emphasis is placed on reducing the leading causes of death, which are, in order, accidents, homicides, and suicides. The leading causes of accidental deaths for children are automobile, bicycle, and drowning accidents, and there are now prevention programs that address each one of these accident types. Many accidental deaths of children (approximately 40%) occur during the summer months, which has obvious implications for the need for better parental supervision.

Parents must know where their children are, whom they are with, and what they are doing. Parents need to know if their children like music, television programs, movies, or video games with violent themes. Most important, they need to be aware if anyone in their child's peer group has access to guns. Many tragic deaths of young people could be prevented if parents paid more attention to their children's activities and associates.

Adults must become more involved and stay involved in the lives of their children. It is true that many adolescents put up barriers and push adults away, but they don't really mean it, even if they think or say they do.

NASP members provided assistance in the aftermath of the tragic school shooting in Santee, California. One of the many lessons learned from that tragedy was that the students wanted adults—specifically their parents and teachers—more involved in their lives. At our suggestion, the principal wrote a letter to all students that contained the following key points:

- The principal honestly acknowledged her own thoughts and feelings.
- Students were given permission to acknowledge a range of emotions and were told that all emotions, even anger, are good. The challenge with anger, however, is to find an appropriate way to express it.
- Students were informed that a wide variety of activities would be provided to let them express their emotions, including talking, writing, music, artwork, projects, ceremonies, and rituals.

Students were then asked to respond to the principal's letter and answer the following questions:

- Where were you when the tragic shooting occurred and what were your sensory perceptions?
- How well did you know any of the students or teachers who were injured or killed?
- How well did you know the student who was arrested and charged as the perpetrator?
- What are you experiencing now and what are you worried about?
- What would make you feel safer at school and what do you need in your life to help you cope?

Within two weeks after the shooting, the principal commented that nearly every student in the school had responded and that this was a very powerful part of the intervention process. The resounding message in every letter was that *the students wanted adults more involved in their lives*.

In the foreword of this book, Rear Admiral Brian Flynn wrote that the "fundamental message of this book is one of both hope and help." The important message we wish to convey in this preface is that hope and help become possible when adults become more involved in the lives of young people. For crisis prevention to occur, adults must reach out to forge meaningful connections. Parents must develop deeper relationships with their children; teachers must become more involved in the lives of their students; young people must become aware of troubled peers and offer them a helping hand; and professionals committed to the education of youth must build partnerships with other like-minded professionals.

The most important lesson we have learned is that the best way to prevent crisis is to become involved in the lives of young people and make sure they are all included. Unfortunately, this lesson has been demonstrated to us time and again; perpetrators of school shootings most often were those who felt ignored, excluded, and bullied. If these troubled youths had felt connected to their parents, peers, teachers, or community, perhaps many lives could have been saved.

So much has been written in recent years about school violence—especially school shootings. NASP was very forward thinking in developing the National Emergency Assistance Team (NEAT) in 1997. Since its inception, NEAT team members have been involved in assisting in the aftermath of every major school shooting that has occurred. NEAT has also forged important partnerships with many professional organizations and agencies, such as the U.S. Department of Education, National Education Association, and the National Organization for Victim Assistance. Team members, many of whom authored chapters in this book, are highly committed to ensuring that students, faculty, and parents receive the emotional assistance they need in the aftermath of a tragedy.

Scott Poland (the first author of this preface) served as chairperson of the NEAT team for its first three years and assisted in the aftermath of many school crises, including the Oklahoma City bombing tragedy. He found that schools and communities often underestimate the initial and long-term impact of a tragedy. Mental health professionals, however, are in a position to determine the resources needed for recovery. They are able to reach out and offer assistance to school staff, faculty members, and parents as well as students. Support needs to be of sufficient duration to ensure the long-term emotional well-being of all affected individuals. This assistance must be guided by research on effective ways to intervene following a crisis.

The search for solutions to school violence has involved the highest levels of our government. NEAT members have testified many times before state legislatures and the U.S. Congress. Questions have been asked about how to spot a troubled child. School personnel are generally able to identify children and families who have mental health needs, but insufficient numbers of school psychologists, counselors, and social workers in the schools make it impossible to properly meet these needs. Again, educators must reach out and forge partnerships with legislators who support mental health assistance for young people.

School administrators would be wise to involve students on safety committees and to implement specific prevention programs to reduce the leading causes of death of children. Past experience has proven that students are almost always aware that a classmate is engaging in reckless behavior or is threatening homicide or suicide. One vital way to ensure that adults are more involved in the lives of students is to emphasize that students are the critical members of school safety teams.

This book contains excellent, up-to-date information from experts in the field of crisis prevention and intervention, and it will be a valuable resource for schools and communities. The editors as well as many of the authors have had firsthand experience in the aftermath of traumatic events. When you read this book, try to think of ways that you can become more involved in the lives of young people. Consider how your school can become a caring place that makes every student an important part of the school community.

We are reminded of the quote from Dac: "The future is the past in preparation." Educators must learn every lesson from this important book and must strive to create safe school environments and a safe future for all of our nation's children. School personnel who are knowledgeable about all aspects of crisis prevention and intervention can make a significant difference.

Acknowledgements

危
機

We wish to thank every author who contributed to this volume and made this work possible. In every sense of the word, this was truly a "team" effort. Special thanks to those authors who served as chapter reviewers (Michael Brown, Stephen Elliott, Ted Feinberg, Michael Furlong, John Kalafat, Sharon Lewis, Jonathan Sandoval, Linda Webster, and Anastasia Yasik) and to all our outside reviewers (Stephen Behnke, Franklin Bernhoft, Andrea Canter, Cathi Christo, Leslie Cooley, Suzanna Grant, Jennifer Kitson, Jane Lazarus, Martin Levine, Adrianna McEachern, Scott Merydith, Kathryn O'Brien, Bernie Stein, David Weber, and Frank Zenere).

We also wish to thank Marilyn Brazier, whose problem-solving skills helped get us through many difficult moments. We thank Linda Morgan, Lesley Carter, and the entire NASP office who gave our project the kind of production attention editors dream about. We would also like to thank the Publications Board for their support of this work. And of course, thank you, Thea Clarke, for your superior copyediting skills.

Dr. Brock would like to thank the Lodi Unified School District and California State University, Sacramento, for their support of his work in the field of school crisis response. Dr. Lazarus appreciates Florida International University and the following school psychology students for their assistance in this project: Marla Arnold, Randi Friedman, Shannon Kelley, and Melanie Laird. He also thanks the NEAT Team family, Ted Feinberg, Susan Gorin, Rich Lieberman, Bill Pfohl, Scott Poland, Kristine Sieckert, and Frank Zenere for their good work and resolute spirit in responding to crises. Dr. Jimerson would like to acknowledge the University of California, Santa Barbara, for its support as he completed this work, and he also thanks school psychology student Amber Kaufman for her assistance.

Finally, and perhaps most importantly, we also acknowledge crisis victims, survivors, and their families from whom we have learned so much.

Reflections on September 11th

危
機

The tragic acts of terrorism on September 11, 2001, have had a profound and lasting effect on all of us, including our nation's youth. The efforts of many professionals, associations, and organizations across the country have been inspiring, because so many provided support and assistance following these catastrophic events. In the days and weeks following these events, contributors to this book were directly involved with providing resources to children and families across the nation. Handouts were written and several chapters of this book were posted on the NASP website within days to serve as resources for school psychologists, school counselors, teachers, administrators, parents, and other professionals.

Because all chapters of this book were completed in August and the book was in press during September, the only mention of these terrorist acts is within these "reflections." Given the magnitude of this tragedy and the content of this book, we each felt that it was important to share brief reflections. Many of the chapters in this book provide valuable information to utilize in working with children and families. We realize that everyone around the world is affected by these events, and we hope this book provides information useful to prepare for future crises and assist children and families.

Although such acts of terrorism in the United States have been few, the effects have been devastating for many. Many children and families experienced the death of a close or special person on September 11th, and their bereavement will continue for years. In addition, many others across the nation and the world have experienced a range of emotions following these events. During such times, the comfort of caring adults, both professionals and loved ones, is an incredible asset. In this book, several chapters comment on the importance of feeling safe and secure and discuss the roles of caring adults in achieving these feelings. Clearly, reestablishing feelings of safety and security will be fundamental to the healing of our nation.

In working with crisis survivors and their loved ones, we have found that family, friends, and faith are fundamental in providing comfort and support. Forging meaningful connections with others, establishing a closer family bond, reaching out to those in need, making a contribution, and drawing strength from one's faith all help in the healing process.

Amidst the tragedy, it is our fervent hope that some good may come out of these horrific acts. We have been touched by the many acts of heroism of our firefighters, policemen, rescue workers, and ordinary citizens. We have been moved by the generous outpouring of support by adults and schoolchildren all across the world. Our nation is coming together with a renewed sense of purpose while grappling with difficult issues regarding safety and security.

Diversity of culture, religion, ideas, and ethnicity each contribute to the richness of our country. It is imperative that we continue to teach children that respect of all individuals is essential. Neil Postman has elegantly expressed the importance of the moral education of our young people in these words, "Our children are the messages we send to a time we will not see."

We express our deepest sympathies to all the victims, their children, and families. Each of us has worked with many children and families during our careers, each with the belief that we can make a positive difference through our actions. In the spirit of constructively moving forward, a thought from Gandhi seems appropriate—"Be the change you want to see in the world."

SEB, PJL, SRJ

Section

1

Introduction: From Theory to Practice

It was the late winter and early spring of 1998/99 when we first began to conceptualize the organization and content of this best practices volume. Initially, our goal was to provide a comprehensive treatment of the topic of school crisis intervention. As our early work progressed, however, we quickly became aware that much more can and should be done to prevent crises and that the *comprehensive* school crisis response team *must* be involved in crisis prevention as well as intervention. Subsequently, making use of Caplan's (1964) three-part model of preventive mental health, the conceptual framework for this volume evolved. With this framework in mind, we have divided this book's focus among the concepts of primary, secondary, and tertiary prevention.

This section contains Chapter 1 by Stephen Brock, which examines crisis theory and establishes a foundation for the comprehensive crisis prevention and intervention team. This chapter aims to bridge the gap between theory and crisis response practice. It does so by operationalizing crisis terminology, and includes clarification of what primary, secondary, and tertiary prevention mean for the comprehensive school crisis response team. This chapter also places subsequent chapters within the book's conceptual framework.

To construct the book's conceptual framework, Caplan's (1964) preventive mental health model has been used to group book chapters within sections. Specifically, Section II (Primary Prevention: Preventing and Preparing for Crisis Events) presents chapters that address preventing and preparing for crises. Sections III and IV (Secondary Prevention: The Immediate Response to Crisis Events and Secondary Prevention: Responding to Specific Crises) present chapters containing information that can be useful when responding to crises, and Section V (Tertiary Prevention: Long-Term Treatment of Traumatized Individuals) offers a review of long-term rehabilitation issues associated with crisis, trauma, and loss. Although many of the activities described in Section V may be beyond the training and skills of the school-based crisis response team, we believe it is essential to include this information and acknowledge the fact that the immediate response (i.e., crisis intervention) is insufficient when addressing the needs of individuals with significant psychological injury (e.g., posttraumatic stress disorder).

Our book concludes with a section that addresses other issues that we believe are important to crisis prevention and response. The book's last two chapters help to define the need for future research in this field. This need for research is an essential, urgent, and often overlooked facet of crisis prevention and intervention. As illustrated by the length of this volume, there is much that we do know about preventing and responding to school crises. At the same time, however, we believe that it is critical to acknowledge that there is still much to be learned. We hope the pages that follow provide a foundation and an impetus to stimulate the production of such knowledge.

Reference

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

1

危機

Crisis Theory: A Foundation for the Comprehensive Crisis Prevention and Intervention Team

Stephen E. Brock, Ph.D.
California State University, Sacramento

Ten years ago Gayle Pitcher and Scott Poland (1992) suggested that crisis intervention appeared "... to be in its infancy in the school setting" (p. 4). As with any infant, it is safe to say that early school responses to crisis events were reflexive in nature. From painful, first-hand experience, the editors of this volume learned that not much planning preceded some of these early school crisis responses. During the infancy of the school crisis response, schools reacted in an almost reflexive fashion when crises occurred.

Books such as Pitcher and Poland's (1992) were written in response to the need for a more reasoned approach. The result of such increased attention is that school crisis teams have begun to mature. Evidence of this growth includes an expanding school crisis prevention and intervention literature (e.g., Brock, Sandoval, & Lewis, 2001; Johnson 1993; Petersen & Straub, 1992). Additional evidence is found in the media reports following school crises. We have observed that, almost without exception, reports of these events end with words to the effect: "crisis counselors will be on hand to help distraught students."

As expectations for school crisis teams continue to develop, school personnel must increase their ability to consciously reflect on the preparation for and provision of these services. When crises occur, it will no longer be acceptable for intervenors to respond in a reflexive fashion to crisis problems and victims. Today's schools must be well prepared to respond to crises. Plans for the provision of crisis services are expected to be in place, which means that school staff members must have the skills to undertake a variety of immediate and long-term crisis intervention tasks. Additionally, as this volume reflects, today's crisis teams should also be prepared to fill a number of crisis-prevention roles.

An understanding of crisis theory is a prerequisite for filling the numerous crisis prevention and intervention roles expected of today's school professionals. Specifically, comprehensive crisis-prevention and intervention team members must know what a "crisis" is, what it means to be "in crisis," and what "crisis response" involves. The goals of this chapter are to provide such understanding as well as to offer a conceptual preview of this book.

What Is a Crisis?

Students face many problems at school that might be referred to as "crises." These events range from failing a test to engaging in playground fights. Although stressful, and often labeled as 'traumatic," most of these events do not require crisis intervention. Given this fact, it is important for crisis response teams to understand the characteristics of events that do require their services. By understanding the defining characteristics of crises, teams will be able to distinguish between potentially traumatic events and those that are just stressful. Without this knowledge, crisis response resources may be inappropriately allocated.

Simply put, truly traumatic crises are not a part of the normal school experience. In fact, they are so far from the ordinary that they overwhelm previously developed problem-solving or coping strategies (Herman, 1992; Young, 1998). In other words, they generate problems initially perceived as being impossible to solve. It is suggested that these events are extremely negative, uncontrollable, depersonalizing, sudden and unexpected, and may have a large-scale impact (Carlson, 1997; Matsakis, 1994; Slaikeu, 1990). Before discussing these characteristics, it is important to note that crisis theorists typically make a distinction between developmental and situational (or accidental) crises. Developmental crises are associated with movement from one developmental stage of life to another (e.g., childhood to adolescence).* The issues these crises generate and their timing are somewhat predictable. Furthermore, they tend to affect individuals one at a time. Situational crises, on the other hand, are much more unpredictable and have the potential to simultaneously impact many people. Because of this potential for a large-scale impact, school crisis response plans typically focus on situational crises.

The characteristics of potentially traumatic crisis events are as follows:

- ***Extremely negative.*** The primary characteristic of a potentially traumatic crisis event is that it is perceived as being extremely negative (American Psychiatric Association, 2000; Carlson, 1997). These events have the potential to generate extreme pain. Specifically, they may cause physical pain, emotional pain, or be perceived as having the potential to cause such pain.

- ***Uncontrollable.*** For a crisis to be traumatic, it must generate feelings of helplessness, powerlessness, and/or entrapment (American Psychiatric Association, 2000; Carlson, 1997; Matsakis, 1994). True crises make people feel that they have lost control over their lives. Whether or not an event generates these feelings has a lot to do with how the event is experienced and perceived. For example, the student who has not been provided earthquake preparedness training will likely find an earthquake to be more traumatic than would students with such training, who know how to protect themselves (e.g., standing under a doorway and away from windows).

- ***Depersonalizing.*** Related to the perceived loss of control, Matsakis (1994) also suggests that traumatic crisis events are those that strip away individuality and humanity. At the moment of the crisis, an individual's self-worth and value have very little meaning. Although degree of impact will vary, most people are affected to some degree by a crisis.

- ***Sudden and unexpected.*** Highly traumatic crisis events occur suddenly and unexpectedly. These are events that people typically believe happen to someone else and have an emergency quality to them (Slaikeu, 1990). Crisis events typically occur without warning. The key factor is that there is very little time to adjust or adapt to crisis-generated problems (Carlson, 1997). It has been suggested that relatively gradual and predictable events (e.g., death following long-term terminal illness, floods, etc.) are less traumatizing than those that are very sudden and unpredictable (e.g., accidental death, earthquakes, random shootings, etc.). It has been speculated that if a crisis is more "predictable," there is more likely to be an opportunity to prepare and make cognitive and emotional adjustments. Thus, it may be perceived as more controllable and may be experienced as less stressful (Saylor, Belter, & Stokes, 1997).

- ***Potential for a large-scale impact.*** Because crisis events have the potential to affect most people, there is the potential for a large-scale impact. Obviously, more severe crises find more people directly or indirectly affected by the crisis. As mentioned, it is this crisis characteristic that creates the need for crisis response teams. While traditional school resources are typically sufficient to intervene on behalf of individuals in need of counseling (e.g., those experiencing a developmental crisis), they are inadequate to deal with large numbers of traumatized people. Severe crises will require more resources than an individual school (or sometimes even a school district) is typically able to provide.

Traumatic Crisis Event Classifications

The American Psychiatric Association's (2000) diagnostic criteria for posttraumatic stress disorder (PTSD) offer a more specific description of potentially traumatic events. According to its *Diagnostic and Statistical Manual of Mental Disorders*, an "extreme traumatic stressor" is defined as follows:

> ... direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat

> to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (p. 463)

Based on this definition, the description of crisis characteristics just offered, and several other sources (Carlson, 1997; Green, 1993; Matsakis, 1994; Slaikeu, 1990; Young, 1998), we offer six classifications for potentially traumatic crisis events. These classifications are severe illness or injury, violent and/or unexpected death, threatened death and/or injury, acts of war, natural disasters, and man-made/industrial disasters. It is suggested that any person who experiences or witnesses one of these events, or learns about one being experienced by a significant other, is a potential psychological trauma victim. Table 1 provides examples of specific events that fall into each of these categories.

It is important to acknowledge that the crisis types listed above do not have equivalent traumatizing potential. Some carry greater risk for psychological trauma then do others. For example, with all other conditions being equal, acts of war or assaultive violence are much more traumatic than are natural disasters (Breslau, 1998). In addition, each event presents unique problems, issues, and crisis-response concerns. For example, the issue of grief will complicate events that include the death of a significant other. To address differences among crisis events, Section IV of this volume (Secondary Prevention: Responding to Specific Crises) offers discussions of specific crisis events (Chapters 22 through 29). In addition, Chapter 18 (Estimating the Appropriate Crisis Response) provides a review of research that will help crisis response teams estimate the potential for psychological trauma generated by different types of crises.

What Is the Crisis State?

While the most important precursor of a crisis is the traumatic event (Roberts, 1990), the individual's crisis experience is also critical (American Psychiatric Association, 2000; Roberts, 1990; Silverman, 1977; Slaikeu, 1990; Taplin, 1971). Simply being exposed to a crisis does not directly lead to psychological trauma, the crisis state, and the need for crisis intervention assistance. Because of this fact, it is critical for crisis response teams to know the defining characteristics of the crisis state. Without this knowledge, teams may fail to appropriately prioritize individual needs for crisis intervention service.

Prerequisites for the crisis state are a crisis event and that the event be perceived as threatening. If the problems generated by a crisis are judged unsolvable, individuals will experience acute distress and enter into the crisis state.

An Apparently Unsolvable Problem

Individuals who enter into the crisis state are presented with problems that they believe are unsolvable. In other words, they are unable to cope with the crisis event using previously developed problem-solving or coping strategies (Lewis, Gottesman, & Gutstein, 1979; Slaikeu, 1990). For example, most students are able to cope with com-

Table 1

Crisis Event Classifications and Examples

Classification	Examples
Severe Illness and Injury:	Life-threatening illnesses. Disfigurement and dismemberment. Road, train, and maritime accidents. Assaults. Suicide attempts. Fires/Arson. Explosions.
Violent and/or Unexpected Death:	Fatal illnesses. Fatal accidents. Homicides. Suicides. Fires/Arson. Explosions.
Threatened Death and/or Injury:	Human aggression (e.g., robbery, mugging, or rape). Domestic violence (e.g., child and spouse abuse). Kidnappings.
Acts of War:	Invasions. Terrorist attacks. Taking hostages. Prisoners of war. Torture. Hijackings.
Natural Disasters:	Hurricanes. Floods. Fires. Earthquakes. Tornadoes. Avalanches/Landslides. Volcanic eruptions. Lightening strikes. Tsunami.
Man-Made/Industrial Disasters:	Nuclear accidents. Airline crashes. Exposure to noxious agents/toxic waste. Dam failures. Electrical fires. Construction/Plant accidents.

Note
From Brock, S. E., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

mon school difficulties (e.g., a fight with a peer) independently or by going to a teacher for help. Following a school shooting, however, these previously developed coping strategies may no longer be viewed as effective. Thus, it may initially appear that there is no way to cope with the fear generated by this crisis event. Because of this apparently unsolvable problem, students will experience acute distress and may require an immediate crisis intervention. On the other hand, students who are able to solve or cope with crisis-generated problems and issues are not in the crisis state and will not require an immediate crisis response.

BEST COPY AVAILABLE

Acute Distress

Because of having a problem that has no apparent solution, the individual in crisis will likely display severe emotional upset or acute distress. These crisis reactions are concrete indications of entry into the crisis state and may include a variety of somatic, behavioral, cognitive, and emotional reactions. Although individuals display a great variety of responses to a common trauma, core symptoms of acute distress include reexperiencing, avoidance/numbing, and increased arousal (American Psychiatric Association, 2000). Individuals who enter into the crisis state and display a significant number of acute distress symptoms for two or more days may be diagnosed as having acute stress disorder. If these symptoms continue for more than four weeks, the individual may be diagnosed as having acute PTSD (American Psychiatric Association). Some signs of these core symptoms are provided in Table 2 (American Psychiatric Association, 2000; Carlson, 1997; Matsakis, 1994; Young, 1998).

Other characteristics of the crisis state include the following:

- ***A time-limited phenomenon.*** The acute distress generated by an apparently unsolvable problem is very intense and cannot continue indefinitely. It has been suggested that people cannot tolerate this distress for long periods of time. Thus, individuals in crisis will engage in attempts to solve crisis-generated problems and thereby reduce this distress. Most crisis theorists agree that the distress characteristic of the crisis state will typically be resolved within six weeks (Slaikeu, 1990). While some crisis issues may remain (e.g., the bereavement process may take years), the acute pain generated by the trauma is usually managed within a few months.

- ***Present both danger and opportunity.*** Crises often redefine how we perceive the world and our place in it. As such, they are situations where the potential for change is great. Defenses are down and suggestibility is high. Crises motivate change. The changes crises mandate present the individual with both opportunity and danger (Caplan, 1964). Those who adaptively cope with a crisis not only no longer feel acute distress, but also have developed new problem-solving strategies. Development of these new strategies not only allows for return to precrisis functioning levels, but also may result in a psychologically healthier and more resilient individual (Caplan, 1964). For example, students may cope with a natural disaster by acknowledging that such disasters are relatively rare and that they can take protective responses (e.g., disaster preparedness). These students are able to return to school, and their precrisis level of functioning, with new adaptive and practical coping strategies. On the other hand, in their attempt to solve crisis-generated problems (e.g., fear of losing contact with family members) other students may decide to avoid leaving their home. While crisis problems may be resolved, some coping strategies are maladaptive and result in a decline in daily functioning.

Table 2

Manifestations of Acute Distress Core Symptoms

Type of Reaction	Symptoms Re-Experience	 Avoidance and Numbing	 Increased Arousal
Somatic	• Reactivity to reminders (e.g., sweating, rapid heart beat, nausea, dizziness, dry mouth, difficulty breathing)	• Sensory numbing	• Abdominal distress • Hot flashes or chills • Frequent urination • Trouble swallowing
Behavioral	• Insomnia • Increased activity • Aggression • Repetitive play • Act as if trauma were recurring	• Avoidance of trauma reminders (e.g., activities, locations, conversations, people, things) • Decreased interest in significant activities	• Social withdrawal • Insomnia • Exaggerated startle
Cognitive	• Intrusive recall • Flashbacks • Trauma nightmares	• Amnesia • Sense of foreshortened future	• Poor concentration • Hypervigilance
Emotional	• Psychological distress with exposure to reminders (e.g., anxiety, anger, guilt, shame, hopelessness)	• Emotional numbing • Impaired affect modulation	• Irritability • Outburst of anger

BEST COPY AVAILABLE

- ***More than simple stress.*** Responses following crises differ from simple stress in several ways. First, people in crisis have lowered defenses and they are very open to suggestion. In contrast, individuals who are "stressed" are typically very defensive. Second, a crisis has the potential for a radically positive or negative outcome. The typical outcome for the individual experiencing stress is either adaptation and survival or a return to the status quo. Finally, although the crisis state has a sudden onset and is of fairly short duration, the stress state usually builds up gradually and is many times a chronic problem (Slaikeu, 1990).

- ***Not mental illness.*** Although the symptoms of the crisis state may be similar to those of pathological states, they are not necessarily signs of mental illness. Given sufficient stress anyone, regardless of how psychologically ill or healthy, can enter into a crisis state (Matsakis, 1994). Simply put, it is a normal reaction to abnormal circumstances (Slaikeu, 1990). This is not to say, however, that mental illness cannot evolve out of, or be exacerbated by the crisis state. This is, in fact, part of the danger of crises. While the crisis state typically resolves itself within several weeks, in some cases it may evolve into chronic PTSD. In addition, crises may act as a magnifying glass for individual behaviors and traits. Such exaggerated coping behaviors can become barriers to crisis resolution (Nader & Pynoos, 1993). A list of psychological problems associated with maladaptive coping is provided in Table 3.

Table 3

Psychological Problems Associated With Maladaptive Coping

- Chronic posttraumatic stress disorder
- Alcohol or drug abuse
- Eating disorders: Bulimia nervosa, anorexia nervosa, compulsive eating
- Compulsive gambling or compulsive spending
- Psychosomatic problems
- Homicidal, suicidal, or self-mutilating behavior
- Amnesia
- Phobias
- Panic disorders
- Delinquent or criminal behavior
- Depression or depressive symptoms
- Dissociation symptoms
- Fainting spells or complex partial seizures
- Psychotic episodes

Note

Adapted from Matsakis, A. (1994). *Post-traumatic stress disorder: A complete treatment guide.* Oakland, CA: New Harbinger; and Mitchell, J. T., & Everly, G. S. (1996). *Critical incident stress debriefing.* Ellicott City, MD: Chevron.

Further discussion of the crisis state and its other manifestations is provided later in this volume. Specifically, Chapter 16 (Developmental Aspects of Psychological Trauma and Grief) provides information on the varied manifestations of the crisis state at different developmental levels. In addition, Chapter 19 (Identifying Individuals At Risk for Psychological Trauma) offers information to assist in the identification of individuals who have been traumatized and are "in crisis." Later, Chapter 30 (Diagnosing Child-Adolescent Posttraumatic Stress Disorder) provides additional information on how to assess PTSD.

What Is the Crisis Response?

With an understanding of the characteristics of "crisis" events, and what it means to be "in crisis," school personnel are in a position to consider the types of responses that a comprehensive crisis prevention and intervention team may offer. Making use of Caplan's (1964) definition of "Preventive Psychiatry," these responses are placed into three general classifications: primary prevention, secondary prevention, and tertiary prevention. The relationship among crisis events, development of the crisis state, and crisis team response options is summarized in Figure 1, on page 14.

Primary Prevention: Preventing and Preparing for Crises

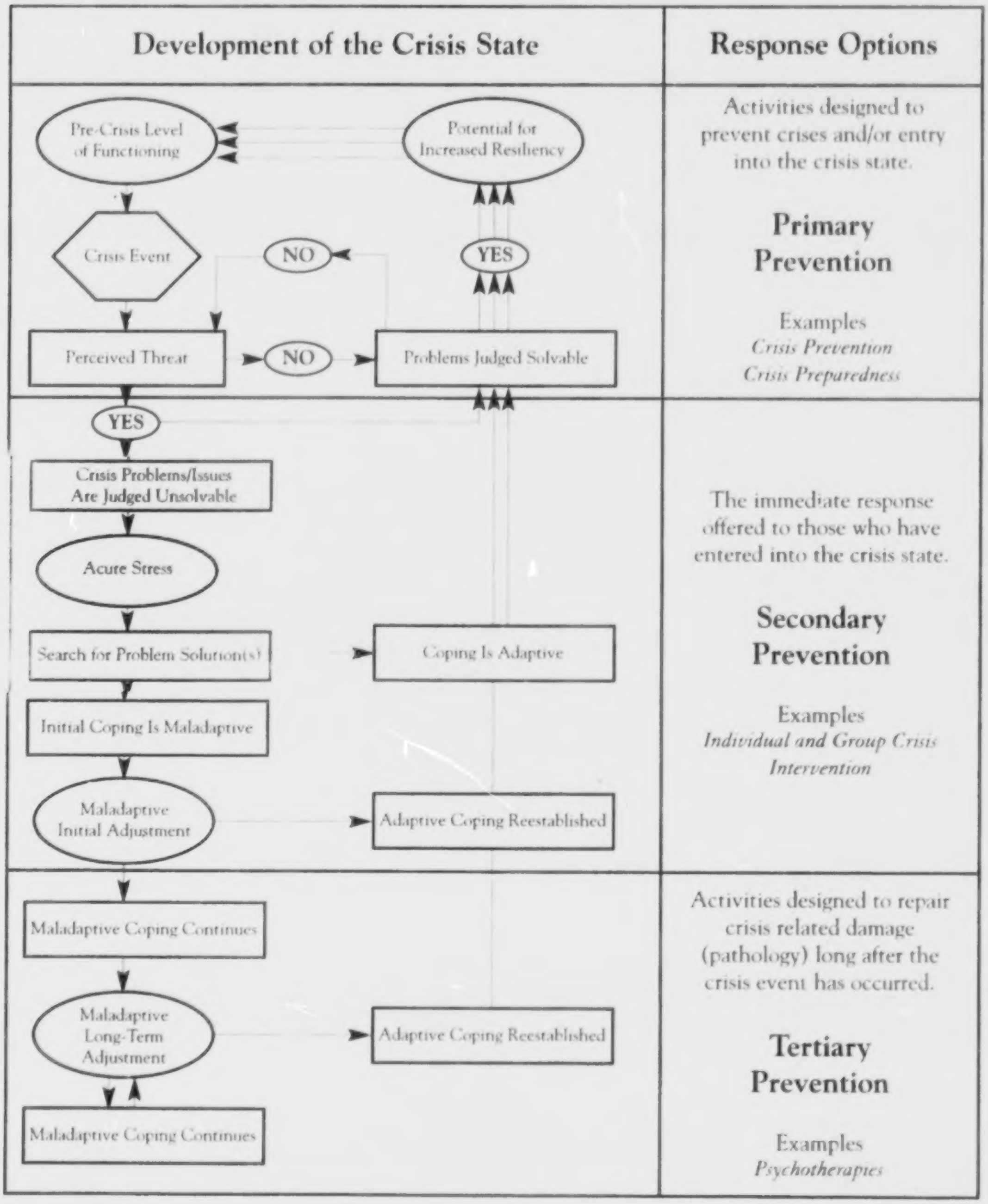
According to Caplan (1964), primary prevention "involves lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before they have a chance to produce illness" (p. 26). Thus, as illustrated in Figure 1, crisis team activities and services provided before a crisis event occurs and/or to individuals who are not presently traumatized are classified primary prevention. Specifically, these activities include crisis prevention and crisis preparedness. Additionally, some crisis team actions that take place immediately after a crisis event may also be classified as primary prevention. Specifically, these activities include crisis team services provided to individuals not presently in crisis (i.e., those who were never threatened by the crisis or who are adaptively coping with a perceived threat). These services might be viewed as both ensuring that individuals do not become traumatized and as having the potential to increase resilience to future trauma by directly teaching adaptive coping strategies.

Crisis prevention. These activities are designed to prevent crisis events from occurring in the first place. Creating safe and nurturing school and classroom environments, identifying youths at risk for self- and other-directed violence, promoting social skills, addressing bullying, and offering anger-management and peer-mediation programs are examples of primary prevention. Further discussion of these activities is provided in Section II (Primary Prevention: Preventing and Preparing for Crisis Events) of this volume (Chapters 2 through 13).

School crisis preparedness. Despite the best crisis prevention efforts, crisis events are an unfortunate reality of life. Preparedness activities acknowledge that it is impos-

Figure 1

The relationship among the crisis event, development of the crisis reaction, and the crisis response. The crisis state is shaded in gray. Depending on its duration, this state might be labeled a crisis reaction (less than two days) or acute stress disorder (more than two days). Acute PTSD is an example of what might be observed as part of a "maladaptive initial adjustment," and chronic PTSD is an example of what might be observed as part of a "maladaptive long-term adjustment."


Development of the Crisis State
Response Options
Pre-Crisis Level of Functioning
Potential for Increased Resiliency
Crisis Event
NO
YES
Perceived Threat
NO
Problems Judged Solvable
YES
Crisis Problems/Issues Are Judged Unsolvable
Acute Stress
Search for Problem Solution(s)
Coping Is Adaptive
Initial Coping Is Maladaptive
Maladaptive Initial Adjustment
Adaptive Coping Reestablished
Maladaptive Coping Continues
Maladaptive Long-Term Adjustment
Adaptive Coping Reestablished
Maladaptive Coping Continues
Activities designed to prevent crises and/or entry into the crisis state.
Primary Prevention
Examples
Crisis Prevention
Crisis Preparedness
The immediate response offered to those who have entered into the crisis state.
Secondary Prevention
Examples
Individual and Group Crisis Intervention
Activities designed to repair crisis related damage (pathology) long after the crisis event has occurred.
Tertiary Prevention
Examples
Psychotherapies

sible to prevent all traumas and include the development of plans and procedures to respond to these events (Brock et al., 2001). Such preparedness is designed to minimize the traumatizing effects of crises and to quickly identify and respond to individuals who are in crisis.

The importance of minimizing the traumatizing potential of a crisis is illustrated in Figure 1. This figure shows that it is possible for a crisis event to initially be perceived as not threatening, but to later become threatening when crisis problems are judged unsolvable. This can occur, for example, if students are exposed to the aftermath of a crisis (e.g., viewing the dead and injured) and/or are unable to be quickly reunited with their parents. Thus, it is important for crisis plans to address issues such as secondary exposure and reunification with families. These and other crisis preparedness issues are discussed in Chapter 14 (School Crisis Preparedness).

Secondary Prevention: The Immediate Response to Crisis Events

According to Caplan (1964), this level of prevention refers to programs designed to reduce the rate of mental disorders "by shortening the duration of existing cases through early diagnosis and effective treatment" (p. 89). Thus, as illustrated in Figure 1, the immediate response offered to those who have entered into the crisis state is referred to as secondary prevention. Individuals in crisis have experienced a crisis event as threatening and perceive crisis problems as unsolvable. As a result, they experience acute distress. Recipients of secondary prevention services, or crisis intervention, may also include (but are not limited to) those considered to have an acute stress disorder or acute PTSD. Examples of this type of crisis response include both individual and group crisis intervention techniques. These techniques and other issues associated with the immediate response to a crisis event are discussed in Section III (Secondary Prevention: The Immediate Response to Crisis Events, Chapters 15 through 21) and Section IV (Secondary Prevention: Responding to Specific Crises, Chapters 22 through 29).

Tertiary Prevention: The Long-Term Treatment of Traumatized Individuals

According to Caplan (1964), this level of prevention refers to programs designed to rehabilitate trauma victims "to return their productive capacity as quickly as possible to its highest potential" (p. 113). The goal is to reduce "the impairment which may result from those [mental] disorders" (p. 17). Thus, as illustrated in Figure 1, crisis team services provided to individuals to help repair crisis-related damage some time after the crisis event has occurred are identified as tertiary prevention. These interventions include psychotherapeutic treatments (e.g., cognitive-behavioral therapy) for disorders associated with maladaptive long-term reactions to crises (e.g., chronic PTSD). While all primary, and most of the secondary, prevention activities are appropriate undertakings for any school crisis-prevention and intervention team, tertiary prevention is clearly a professional mental health intervention. This response requires long-term psychological and psychiatric treatments that are typically beyond what most educators can provide. Instead, mental health professionals provide these services. Further discussion of these longer-term mental health treatment issues is provided in Section V of this volume (Tertiary Prevention: Long-Term Treatment of Traumatized Individuals, Chapters 30 through 33).

Concluding Comments

As conceptualized in this volume, school crisis response teams have to fill a number of different prevention and intervention roles. We hope that this volume provides guidance to school professionals who attempt to fill these roles. We also intend for this volume to address some of the special challenges facing school crisis prevention and intervention. Thus, the reader will find in Section VI (Special Issues in Crisis Prevention and Response) chapters dealing with legal and ethical issues (Chapter 34) and how to advocate for crisis prevention and intervention in schools (Chapter 35). Finally, and arguably most importantly, the volume concludes with two chapters (Chapters 36 and 37) that address the need for continued school crisis prevention and intervention research. Although the literature has evolved to the point where volumes such as this book can offer educators guidance, much still needs to be learned. School crisis prevention and intervention has matured significantly in the past decade, but ongoing study is critically needed to address many unanswered questions.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Breslau, N. (1998). Epidemiology of trauma and Posttraumatic Stress Disorder. In R. Yehuda (Ed.), *Psychological trauma* (pp. 1-29). Washington, DC: American Psychiatric Press.

Brock, S. E., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Carlson, E. B. (1997). *Trauma assessments: A clinician's guide*. New York: Guilford Press.

Green, B. L. (1993). Identifying survivors at risk: Trauma and stressors across events. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 135-144). New York: Plenum Press.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Johnson, K. (1993). *School crisis management: A hands-on guide to training crisis response teams*. Alameda, CA: Hunter House.

Lewis, M. S., Gottesman, D., & Gutstein, S. (1979). The course and duration of crisis. *Journal of Consulting and Clinical Psychology*, *47*, 128-134.

Matsakis, A. (1994). *Post-traumatic stress disorder: A complete treatment guide*. Oakland, CA: New Harbinger.

Mitchell, J. T., & Everly, G. S. (1996). *Critical incident stress debriefing: An operations manual*. Ellicott City, MD: Chevron.

Nader, K., & Pynoos, R. (1993). School disaster: Planning and initial interventions. *Journal of Social Behavior and Personality*, 8, 1-22.

Petersen, S., & Straub, R. L. (1992). *School crisis survival guide: Management techniques for counselors and administrators*. West Nyack, NY: Center for Applied Research in Education.

Pitcher, G., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.

Roberts, A. R. (1990). An overview of crisis theory and crisis intervention. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment and research* (pp. 1-15). Belmont, CA: Wadsworth.

Saylor, C. F., Belter, R., & Stokes, S. J. (1997). Children and families coping with disaster. In S. A. Wolchik & I. N. Sandler (Eds.), *Handbook of children's coping: Linking theory and intervention* (pp. 361-383). New York: Plenum.

Silverman, W. H. (1977). Planning for crisis intervention with community mental health concepts. *Psychotherapy: Theory, Research and Practice*, *14*, 293-297.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Newton, MA: Allyn & Bacon.

Taplin, J. R. (1971). Crisis theory: Critique and reformulation. *Community Mental Health Journal*, *7*, 13-23.

Young, M. A. (1998). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

Section

2

Primary Prevention: Preventing and Preparing for Crisis Events

危機

BEST COPY AVAILABLE

Responding to school crises is not enough. Schools must actively develop and implement programs that prevent crises from occurring. To do so, crisis prevention and intervention team members must have a thorough understanding of the characteristics of safe schools and guidance in implementing research-based practices that promote safe schools. Such is the focus of the chapters that comprise this section.

In the first four chapters, the authors focus on how to make schools safe and responsive. These chapters make it clear that all schools must have crisis-prevention teams and that these teams should provide leadership to promote a school climate that supports programs aimed at fostering safety, academic competence, and socially appropriate behavior. Specifically, in Chapter 2, Kevin Dwyer and Shane Jimerson discuss how to prevent crises through planning and describe crisis team development and models for prevention. Chapter 3, by Ron Stephens, outlines specific strategies that schools can use to make their campuses safer. In Chapter 4 Robert Brooks describes the activities that teachers can incorporate into their classrooms to foster hope and resiliency in their students, and in Chapter 5 Ted Feinberg and Susan Jacob describe a risk-management approach that administrators may use to make their schools safe and to prevent liability.

The next five chapters offer what the Institute of Medicine (1994) might label *universal* prevention programs (i.e., they are directed toward an entire population). First, Bonnie Aberson and Myrna Shure describe in Chapter 6 how the I Can Problem Solve program can teach young children to solve problems in constructive ways to avoid violence. Next, Chapter 7, by Michael Furlong, Renee Pavelski, and Jill Saxton, describes how to think strategically about violence prevention to understand how best to develop and implement violence prevention programs and strategies in schools. Three other chapters that can be labeled *universal* prevention programs deal with more specific prevention issues, including promoting social skills and socially supportive learning environments (Chapter 8 by Stephen Elliott, Brian McKevitt, and James DiPerna), bullying in schools (Chapter 9 by Carla Garrity, Kathryn Jens, William Porter, and Sally Stoker), and peer mediation (Chapter 10 by Robert Myrick).

The next three chapters offer what the Institute of Medicine (1994) might label *selected* or *indicated* programs (i.e., they are directed toward specific at-risk or high-risk populations). Specifically, they address the issues of school suicide prevention (Chapter 11 by John Kalafat and Philip Lazarus) and aggression replacement training (Chapter 12 by Arnold Goldstein and Barry Glick). In addition, discussion is offered regarding how to identify youth at risk for self- and other-directed violence (Chapter 13 by Sharon Lewis, Stephen Brock, and Philip Lazarus).

The last chapter in this section recognizes that, despite the best of prevention efforts, it is impossible to stop all school crisis events. Given this reality Chapter 14, by Stephen Brock and Scott Poland, offers a discussion of how schools can prepare for crises. It sets the stage for chapters within sections III and IV, which focus on secondary prevention (or the immediate response to crisis events).

Reference

Institute of Medicine. (1994). *Reducing risk for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

38

2

危機

Enabling Prevention Through Planning

Kevin P. Dwyer, M.A.
National Mental Health Association

Shane R. Jimerson, Ph.D.
University of California, Santa Barbara

Promoting the cognitive and social competence of all students is central to accomplishing our national educational goals (National Education Goals Panel, 2000). Establishing comprehensive school-based programs to facilitate academic and socioemotional development will reduce behavior problems and associated deleterious outcomes (Greenberg, Zins, Elias, Weissberg, in press; Lewis, Sugai, & Colvin, 1998; Roeser, 2001; Roeser & Eccles, 2000). For example, a good reading program can prevent discipline problems caused by frustration and failure and a good social-behavioral, mental wellness program can improve reading achievement by increasing instructional time (Skinner & Smith, 1992). Together, an effective reading program and effective social skills program can significantly increase the learning and adjustment of children (Slavin & Fashola, 1998).

Developing schools that enable every child to succeed requires the use of effective, theory-based, researched practices that address the needs of today's youth. We can no longer afford to repeat failed educational practices and interventions (American Institutes for Research, 2000; U.S. Department of Health and Human Services, 2001). Effective schoolwide programs that emphasize both high academic standards (e.g., reading, math, and science) *and* psychosocial skill development are primary prevention programs that can improve literacy and empathy and increase overall competence. The combination of effective instruction within comprehensive and strategic school reform requires effective planning.

This chapter addresses how to plan for this necessary and newly acknowledged responsibility of promoting the cognitive and social competence of all children through comprehensive educational programs. Steps and considerations are suggested for planning and implementing such programs. The critical role of pupil services in accomplishing these goals is outlined for consideration and application.

Establishing a Prevention Planning Team

The first step in developing a comprehensive plan is to identify a few key individuals who can provide leadership in creating a comprehensive plan. It will be essential to have administrative support and assistance in overcoming a variety of possible barriers throughout the process. The core team members will be responsible for organizing the planning team, building an effective team, and sustaining the planning process. When creating a comprehensive plan it is essential that the team use data and complete an assessment of strengths and needs. The following discussion addresses each of these important elements in establishing the prevention planning team.

Develop a School-Based Team Approach

Many schools that have successfully addressed their behavior problems have formed a core team to provide leadership and support to the entire school community, to model an effective problem-solving approach, and to ensure that the approach chosen to address behavior problems remains both effective and consistent with the school's goals and climate (Curtis & Stollar, 1995). At a minimum, this team should include an administrator, a teacher, and a professional skilled in the psychosocial, learning, and behavioral development of children (e.g., school psychologist, social worker, counselor, or other child mental health professional). This team can provide both systemic and child-focused consultation to staff, helping them address systemic factors affecting academic and behavioral standards and results, as well as to families. The team also provides, directs, and monitors interventions for children with, or at risk of developing, emotional and behavioral barriers to learning. Furthermore, the team can facilitate coordinated services for those children who need intensive, multisystemic interventions. Such teams have had positive effects on outcomes for children with emotional and behavioral problems (Hoagwood & Erwin, 1997). The core team can help address both the troubled child and the troubling ecological factors within a responsive school to produce positive outcomes.

Identify Core Team Members

Three professionals (principal, master teacher, and mental health professional) are recommended to initiate and facilitate strategic planning (Dwyer & Osher, 2000). These core team members are fundamental not only to schoolwide mental health and violence prevention efforts, but also to educational excellence. This team has the responsibility for framing the steps to ensure that an effective, integrated action plan is developed, implemented, and evaluated. This team should coordinate its activities with all relevant school and community efforts. This coordination prevents duplication and fragmentation of services, while preventing troubled students from "falling through the cracks" in the service system. The core team must have the necessary skills and vision to design and implement meaningful change.

According to Fullen and Stielgelbauer (1991), "It is possible to be crystal clear about what one wants and be totally inept at achieving it," or to be a skilled change agent "... but empty-headed about what changes are most needed" (p. 5). Leaders in education reform suggest that too frequently both the ineptness at managing change and the lack of vision are co-occurring conditions in schools and other agencies (Knoff, 1996). Too frequently schools and policymakers continue to address problems as discrete issues, seeing youth violence as separate from mental health, separate from substance abuse, and separate from attendance, academic, and dropout problems. Symptom-driven plans frequently are reactive, do not address the underlying factors that are associated with a multitude of problems, and ignore research that demonstrates symptoms frequently co-occur and peak during adolescence (Allensworth, Lawson, Nicholson, & Wyche, 1997). Thus, it is essential to establish coordinated and comprehensive school-community programs.

Ensure Administrative Support

Initially it is important to establish and ensure system support. Planning for change requires a directive or, at a minimum, "permission" from top-level administrators to begin the process. Gaining greater administrative support may become part of the team's initial task. Whenever possible, however, school system leadership buy-in should be secured before establishing a planning team. Without system leader support and some assurance that plans will be implemented, community and staff may lose trust and hope in developing effective intervention plans to address students' psychosocial needs. Several critical logistical steps include: (a) ensuring administrative buy-in, (b) securing a planning budget, (c) designing a communication process, (d) securing authority to identify planning team members, and (e) supporting staff for scheduled meetings.

Many questions should be addressed when planning and securing administrative buy-in. Following are sample questions from several dozen that may need to be addressed (Knoff, 1998): Can school personnel in designated schools be released for five to seven days of additional training/supervision? Can the district fund teacher substitutes to release teachers for training? Is there a willingness to reassign pupil services staff, as necessary, to support the planning and implementation? Can the district fund consultants for training? Can the district provide funding for materials/supplies? Can the district support staff in applying for grants and foundation and community funds? The planning process requires asking hard questions and garnering assurances that can help maintain the plan over time. Sustaining effective planning and implementation is dependent on both positive outcomes and administrative support.

Overcome Barriers

Strategic planning is difficult; it takes time and requires process, facilitation, and consultation skills as well as an in-depth knowledge of resources and internal and cross-system coordination (Adelman, 1996; Knoff, 1996). In-school coordination may not be easy. Some individuals may not see the links between violence prevention and their reform of instruction, curriculum, pupil services, or special education. Staff may be suspicious of "change," fearing more will be added to their responsibilities without adequate support or funding. Others whose symptom-focused teams have been working for a long time and have established roles and responsibilities may find new initiatives disruptive or even threatening.

Some schools have overcome these barriers by demonstrating in their needs analysis that valuable time is presently being used ineffectively in responding to persistent problems such as class disruptions. The connections between improved classroom management, positive behavioral interventions, effective academic instruction, and violence prevention can be presented. Similarly, reaching out to existing groups of staff and aligning the strategic vision with the work of these groups can reduce or eliminate friction. The barriers of limited time and resources can be partially addressed by information that demonstrates the inefficiencies of fragmented services. The principal or school management team may develop practices to reduce wasteful demands on staff time. Schools that have done this have increased opportunity for staff to collaborate and participate in strategic plans, their implementation, and evaluation.

Organize the Prevention and Implementation Team

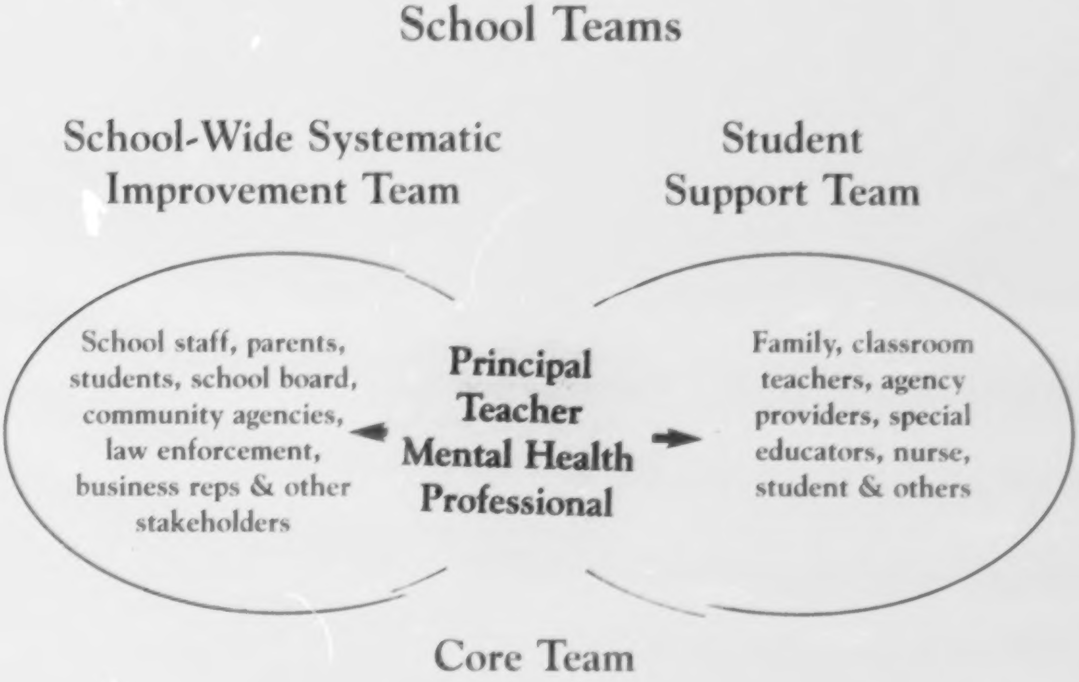
Members of the team should have diverse and complementary skills, that is, individuals who can contribute knowledge or resources to the team. It is important that each member of the team be willing and able to make a commitment to this team. It is critical to have a core group from the school(s) who are volunteers for the task and are dedicated to the vision of the program. The prevention planning and implementation team should have, at a minimum, an administrator (school principal), teaching staff representative (master teacher/special educator), a school mental health representative (school counselor, psychologist, or social worker), a knowledgeable parent representative, and student representative (see Figure 1). To ensure comprehensive planning and future coordination of prevention and intervention services, schools must involve a variety of community leaders and agency members. Groups to consider include: (a) parent group leaders, such as PTA officers, and diverse advocacy group leaders (including disability groups); (b) family agency and family resource center staff; (c) law enforcement personnel (including attorneys, judges, and probation officers); (d) clergy and other representatives of the faith community; (e) media representatives; (f) mental health and child welfare personnel; (g) physicians and nurses; (h) nongovernmental community service organizations (e.g., Big Brothers, Big Sisters, mental health associations); (i) business leaders; (j) recreation, cultural, and arts organizations staff; (k) youth workers and volunteers; (l) local officials, including school board members and representatives from special commissions; (m) interest group representatives and grass-roots community organization members; (n) college or university faculty; (o) members of local advisory boards; and (p) influential community members. This expanded team should have the responsibility for developing the prevention and implementation plan. The expanded team will need to be maintained for a long period, through planning, implementation, and evaluation. Initially, this team will need to meet frequently; once the plans are implemented, it will only meet periodically to advise and respond to the evaluation of the plan's effectiveness.

Build an Effective Team

Once this group has been assembled, there is no assurance that its members will function as an effective team. This process takes time and requires trust and a shared vision. Discussion of the shared vision will take time and may need to be periodically reviewed to keep the team focused. Individual members should make a commitment to participate in all relevant team activities. Changes in team membership have an impact on team dynamics and functioning. Thus, it is important the core team members remain consistent and provide stability to the planning and implementation tasks and interpersonal processes. Team members should be supported in their roles by being provided the necessary information to ensure their participation.

Select a team leader. The team should decide on a leader or facilitator. The leader or facilitator keeps the team task-focused and productive, while ensuring that process needs are addressed and any interpersonal conflicts are resolved. Resources should be provided to the team, including a recorder to ensure the proper dissemination of notes and information. The team leader should be responsible for sharing information on the progress of the planning team with the critical school system leadership.

Figure 1


School Teams
School-Wide Systematic Improvement Team
Student Support Team
School staff, parents, students, school board, community agencies, law enforcement, business reps & other stakeholders
Principal
Teacher
Mental Health Professional
Family, classroom teachers, agency providers, special educators, nurse, student & others
Core Team

BEST COPY AVAILABLE

Establish a timeline. It is critical for the team to be aware of the time required for effective planning. Providing reasonable timelines reduces team friction. Over time, as members support each other and accomplish objectives, a feeling of trust and mutual respect will emerge. It should be anticipated that 6 to 12 months of planning is generally required before implementing complex, multicomponent prevention and intervention programs. It will take even longer to implement the plan completely and measure its effects. Thus, throughout the process, it is important to set realistic timelines and expectations. Map out a timeline to make sure all know that the intensity of meetings will diminish over time. When additional individuals join the team at various times, efforts must be made to include them.

Identify relevant policies. Policies and practices can be significant barriers to change. For example, if the school system's practice is to evaluate school psychologists on numbers of assessments per month and systemic, strategic planning is not valued as a critical responsibility, a change in role may create a serious conflict. Such conflicts are removed when the system's leadership acknowledges the strategic planning and waives the previous evaluation measures. Role changes are difficult to carry out unless agreed to by relevant authorities. Many of the prevention and intervention programs require willingness on the part of school boards or superintendents to effect change. The willingness also includes long-term budgeting for training and staff.

Innovative changes go beyond the schoolhouse walls and may involve assistant superintendents of special education, pupil services, and instruction, among others. Frequently, effective comprehensive plans require interagency agreements for services and interwoven budgeting among agencies and school divisions. Finally, a research and evaluation component is anticipated in any plan and the team will need to determine if that evaluation will be carried out by an independent partner (e.g., university researchers), by the team itself, or by the system's research department.

Sustain the Planning Process

Community involvement will enhance the planning process. Communicating with community stakeholders on a regular basis is therefore critical. Your planning team may decide to schedule face-to-face meetings with the school community as a whole or with different stakeholder groups. The more the community knows about the plan the greater the chance that concerns are addressed and support is given. Work with school-community representatives or a representative of the stakeholder group to identify potential questions and to prepare an agenda that presents clear information and invites comment to maximize the impact of each meeting.

It is important to include the entire school and community in this knowledge sharing. Encourage the school-community team to keep meetings open to other interested community members. Consider having core team members present at community meetings (e.g., houses of worship, community business groups). Team members should attend a variety of meetings with different constituents, such as each school's PTA, and parent and student groups representing various cultures and ethnicity. Find out if groups want progress updates and provide them.

Throughout this planning process, solicit feedback from individuals through focus groups to determine the inclusiveness of the plan. Validate or revise your information and listen for new ideas. In addition, talk to community groups and individuals to solicit their interest in being involved in the next stage of the prevention and implementation plan.

Complete an Assessment of Strengths and Needs

A solid plan depends on a thorough understanding of the school and community. Thus, it is important to utilize data in the planning process. An agreed-upon school-community assessment of needs and strengths is critical. The team needs to acknowledge the ground rules regarding the assessment (scientific rather than anecdotal, real resources rather than paper programs) and design plans using the integrated, ecological theory of prevention, early intervention, and targeted intensive intervention. The team is responsible for identifying the necessary data for consideration.

Use available data. Much of the data to be included in the strengths and needs assessment are readily available. For example, schools collect data on grades, performance on standardized tests, promotion and retention, referrals for special education, referrals to community agencies (including law enforcement and child protective services), attendance, disciplinary referrals and actions, serious incident reports, and demographics. Many schools also collect data on volunteers (e.g., mentors and tutors, business partnerships), student community service, awards, after-school programs, and interagency agreements. In addition, administrators and schoolwide management teams frequently collect data on class size and participation in extracurricular activities.

Use additional data. Although these sources are informative, they do not always include all the relevant data. For instance, information about community housing, crime rates, and factors associated with employment and poverty may be valuable. Similarly, the team may want to examine information regarding family and community factors, such as mobility, overcrowded or substandard housing, and access to conveniences; the numbers of children who are latch-key, homeless, migrant, immigrant; and data on positive and negative experiences that students have on the way to and from school (e.g., with crossing guards, bus drivers, gangs, and/or drug abusers).

Gather additional data through various methods. The team may want to assess student and faculty attitudes regarding key issues of student support and safety (e.g., bullying and harassment). Hence, it may be important to solicit information from students, staff, families, youth development organizations, police, family and child service agencies, and other members of the community. Anonymous surveys completed by students, staff, and parents can be useful. California and other states have developed effective questionnaires for this purpose (California Department of Education, 2001; Furlong & Morrison, 1994). In addition, observations in classrooms, the cafeteria, and on busses can provide information regarding interactions among students and adults. To gather data for the strengths and needs assessment, the team may use approaches such as surveys, observations, focus groups, town meetings, and analyses of relevant databases.

The team should use the results of the strengths and needs assessment to determine programs, interventions, or components that show strong positive results, programs that require modification or support, programs that require major overhaul, and programs that should be developed or discarded. The data gathered during the planning phase can also be used as the baseline for future evaluation of the efficacy of the intervention efforts.

Planning for Safe, Effective, and Responsive Schools: Core Elements

The federal response to the school-site multiple shooting tragedies in the past decade has focused the public's energy on helping our nations' schools become safer, more caring environments conducive to learning. The U.S. Departments of Education and Justice in coordination with the Department of Health and Human Services have provided direction moving toward the development of positive solutions. The first product was the document, *Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer, Osher, & Warger, 1998). The *Early Warning Guide* was completed in a timely manner and distributed to the nation's schools during September 1998. By the year 2000 over one million copies of the document had been distributed to schools, agencies, community organizations, and individuals. The second document, *Safeguarding Our Children: An Action Guide* (Dwyer & Osher, 2000) was mailed to all schools in June 2000, to help schools implement the principles found in the *Early Warning Guide*. The *Action Guide* contains descriptions of evidence-based programs and practices for school communities to use to address the academic, emotional, behavioral, and safety needs of *all* children. With prevention as the focus, these *Guides* emphasize the need for schools to examine the environment they provide children. These two documents provide the foundation for considering the need for implementing a comprehensive safe school plan. Below is a brief discussion of core elements the team should consider during the strategic planning process.

Conceptualize a Responsive School

Responsive schools include not only high standards, but also strong family connections. Responsive schools employ caring staffs that are trained and knowledgeable in supporting social skills and in recognizing when children need help. Responsive schools need to examine the 13 key characteristics of effectiveness as outlined in Figure 2, on page 32. This process is critical to the needs and resource mapping required in the early stages of developing a comprehensive plan. Because interventions should address existing needs and utilize available supports, each characteristic requires a thorough analysis prior to the development or implementation of any interventions.

Responsive schools build resiliency for all children, including those children placed at risk by other factors (Gottfredson & Gottfredson, 1985; Yoshikawa, 1994). Responsive schools report, monitor, and address the precursor behaviors and problems that may lead to violence. For example, a frequent cause of conflict among students, and between students and staff, is perceived or actual bias that can result in bullying, rejection, or unfair treatment. Bullying can result in the escalation of violence by the victim against others (Batsche & Knoff, 1994). Schools can share this information about bullying and other precursor behaviors with families, students, and related community groups as an early step toward problem solving.

Promote Positive Relationships Among Students and Staff

In considering whether the school is a caring environment, it is important to consider how frequently the school structures ways for students to meet with staff to discuss academic, emotional, and behavioral issues. Questions to consider include: Is there easy student access to pupil services staff such as counselors, nurses, school psychologists, and others? Does the school provide a full array of extracurricular activities? Does the school include students in establishing goals, discipline policies, and the like? Does the school staff demonstrate intolerance for bullying and all forms of prejudice? As a planning team answers these questions, and develops its own questions, it is critical to connect the answers to measurable activities or examples of behaviors or practices that operationalize these statements. For example, when asking students about bullying, it is critical to ask questions about how the adults in the school inhibit, ignore, or exacerbate the problem of bullying.

When examining problem solving and peer caring, it may be valuable to look at the school's conflict resolution program, including its management and support. Consider the training of staff and support for staff in seeking help for students who may need different, more intensive instruction or behavioral support. Questions to consider include: Are practices in place for students to be encouraged to both formally and informally support each other through activities and peer tutoring, mentoring, and buddy systems? Has the school prioritized resources to enable students and staff to seek the support they may need (e.g., easy access to pupil service consultants, phones, time, training in social skill and problem-solving instruction)? Does the school train staff and have practices that use behavioral conflict as an opportunity for learning and for relationship building? Are staff members developing positive relationships with both students and their families? Does the school address teaching tolerance and reaching out to be inclusive of all groups? When reviewing these questions and others to determine your environmental assets, it is important to seek input from the broad community, remembering to be inclusive of persons frequently overlooked. For example, if the student input is from student government leadership and the team is examining "caring staff" factors, the information is likely to be positively skewed.

Solutions to problems may require reallocating resources, changing school schedules, or requesting additional training or funding. Many solutions, such as an improved

Figure 2

The following chart is an example of the kinds of questions a school team may examine as it strives to make the school safe, effective, and responsive (adapted from Dwyer, 2001).

Checklist of Key Characteristics of Effective Schools

Positive Trait "My school…"	Existing Activities	Rating		Needs To Be	Developed Actions
		+	-		
• Focuses on academic achievement.					
• Involves families in meaningful ways.					
• Develops links to the community.					
• Emphasizes positive relationships among students and staff.					
• Discusses safety issues openly.					
• Treats students with equal respect.					
• Creates ways for students to share their concerns.					
• Helps children feel safe expressing their feelings.					
• Has in place a system for referring children who are suspected of being abused or neglected.					
• Offers extended day programs for children.					
• Promotes good citizenship and character through teaching and supporting social problem-solving skills.					
• Identifies problems and assesses progress toward solutions.					
• Supports students in making the transition to adult life and the workplace.					

++ very strong + strong - needs improvement -- needs development/change transition program and a well-monitored conflict resolution program, require a minimum of additional funding. Other options for improving student and staff relationships include: (a) creating and supporting planned activities in which students and adults can interact to share their concerns, and learn from each other (e.g., clubs or after-school activities); (b) providing opportunities for well-supervised and trained students to interact and assist one another (e.g., peer tutoring, mentor programs, buddy systems, school service projects, peer counseling); and (c) establishing a bullying prevention program as part of the school's social skill program (Olweus, 1994, 1996). Research has shown that providing opportunities for quality intergenerational activities can also affect schoolwide success (Mortimore, 1995). Developing positive relationships among students and staff facilitates a caring atmosphere that enables children to see more adults as supportive problem solvers. In such environments, students are likely to resolve conflicts positively and succeed academically.

Create Ways for Students to Share Concerns About Safety

Safe schools ensure that students have ways to openly and safely communicate their safety concerns to adults who will listen. Actively responding to student concerns increases the likelihood that students will report troubling behavior that may lead to violence. The likelihood of students and families sharing information about their safety concerns is related to the responsiveness of those with whom the concerns are shared. Assessing the openness of communications may seem difficult, but recording and measuring the numbers and methods used to reach out to youth and families is one way to accomplish it.

Questions to consider include: Does your school provide opportunities for students to discuss violence and safety (e.g., some schools hold assemblies where students and adults from the school community share ideas about how to deal with violence, intimidation, and bullying)? Are students' ideas and proposed solutions reported as such and incorporated into practices and policies? Are student safety surveys conducted at least yearly, and are results shared and used to address concerns? When a student reports a personal or individual concern, is that student given positive feedback for that effort and is that student provided counseling support if feeling conflicted about expressing concerns? Are teachers trained to take student concerns seriously and are policies in place so that students can safely report concerns and seek help for themselves or classmates (e.g., are students who share information about a classmate made aware that a helpful solution can be/is generated)? Does the school encourage students to talk to their parents? Are parents familiar with the "what-to-do" procedures if there is a possible threat of danger?

When trust is yet to be developed, schools have used such strategies as an anonymous phone hotline for students to report potential violence or "help boxes" where students may leave notes of concern for multiple daily reviews by designated school team members. Although hotlines and help boxes may be unproven, properly used they may assist some individuals in coming forward. Involving students in problem solving and providing them feedback that their opinions matter in forming policies and practices may be more effective than anonymous systems. It is important for the school to demonstrate that effective solutions are the common outcomes for reporting a concern about bullying, harassment, and violent threats and that there are win-win solutions for sharing concerns about school safety. Protection from retribution is also critical, and schools should have in place procedures to protect students who report potential violence, bullying, or intimidation.

To demonstrate to students that the school staff cares, it is important to acknowledge the discipline issues that trouble students. To involve students, team members may want to start with focus groups talking about student perspectives in ranking safe places in the school or evaluating the importance and effectiveness of school discipline rules and practices. It may also be helpful to have students review the results of anonymous surveys, validate concerns, and suggest solutions. Placing student recommendations in the student handbook reaffirms the importance of the students' role in problem solving.

Embrace Prevention and Early Intervention

Schoolwide systemic prevention is the foundation for an effective intervention approach (Curtis & Stollar, 1995; Elias et al., 1997; Hunter & Elias, 1998). School communities traditionally begin to address problems after the problems have surfaced (Hawkins & Catalano, 1992). To prevent social chaos and violent hostility we must teach social and behavioral skills early.

Social and problem-solving skills training, effective academic and behavioral instruction, caring faculty, effective leadership, family involvement, community support, and other components of the responsive school are required to ensure that all children become literate and responsible. Principles for effective interventions include community coordination, family focus, cultural competence, and services that respect individual and family rights to privacy. Interventions must be easy to access and available early. They must be sustained, comprehensive, properly implemented, and evaluated. Furthermore, interventions should be based on an ecological, functional, and developmental analysis of the behavior to determine the necessary course of action (Skiba, Waldron, Bahamonde, & Michalek, 1998).

Psychological consultation and program interventions in school produce better student outcomes and less teacher frustration, as well as reduced costs and overuse of other community services (Adelman & Taylor, 1998). However, it is critical that such psychological and social-behavioral services are both connected to families and integrated into and supported by the school's staff (Adelman, 1996). In framing the principle of prevention, the *Action Guide* placed a strong emphasis on the environment that children are exposed to and based the prevention theory on a social development model that focuses on the interaction between the child and her or his environment

(Hawkins & Weis, 1985). Although each child's early environment is critical to mental and emotional health, the *Guides* (Dwyer et al., 1998; Dwyer & Osher, 2000) only addressed the school years: kindergarten through the high school years.

Establish School-Community Collaboration

Even in communities plagued by serious violence, the school can become the focus for child and family safety by linking other services to the school, including health services, after-school programs, and daycare, and by providing the place where everyone concerned about children and youth can safely gather. Sheras, Cornell, and Bostain (1996) have shown that the risk of school violence increases in communities where links are weak. In addition to reducing violence, research suggests that school-community, family-friendly, coordinated services are also cost-effective (Woodruff et al., 1999).

Review Characteristics of a Safe School Building

The physical condition of the school building also has an impact on student attitude, behavior, and motivation to achieve. Typically, there tend to be more incidents of fighting and violence in school buildings that are dirty, too cold or too hot, filled with graffiti, in need of repair, or unsanitary (Dwyer et al., 1998). Prevention planning starts by making sure the school environment is a safe and caring place that communicates a sense of security. Strategies for enhancing safety on campus include: (a) supervising access to the building and grounds (Stephens, 1994), (b) reducing class size and school size (Haller, 1992), (c) modifying traffic flow patterns to limit potential for conflicts or altercations (Nelson, 1996), and (d) conducting a building safety audit in consultation with school security personnel and/or law enforcement experts (Cornell, 1998; Crowe, 1990). (See Chapter 3, Promoting School Safety, in this volume for further discussion and numerous strategies for increasing school safety.)

Reduce Problems Through Positive Policies

It is also important for the school plan and policies to reduce other opportunities for inappropriate behavioral violence precursors such as a disorderly and undisciplined school or one that functions like a prison. Policies that prevent bullying or intimidation are proactive and improve discipline (Skiba, Peterson, & Williams, 1997). Plans are successful when they ensure that rules are clear, broad-based, and fair (Batsche & Knoff, 1995) and disciplinary procedures are developed collaboratively by representatives of the entire school community (Colvin, Kameenui, & Sugai, 1993; Colvin, Sugai, & Kameenui, 1993; Gottfredson, Gottfredson, & Hybl, 1993). Discipline procedures must be positive, followed consistently, and communicated clearly to all parties. When negative consequences (such as withdrawing privileges) are used in discipline, they should be combined with positive strategies for teaching socially appropriate behaviors (Hyman & Perone, 1998; Rutherford & Nelson, 1995; Shores, Gunter, & Jack, 1993).

Recognize Warning Signs

The *Guides* (Dwyer et al., 1998; Dwyer & Osher, 2000) distinguish between early and imminent warning signs. Early warning signs presented in the *Guides* are behaviors or conditions that suggest a child is troubled by factors which, when left unaddressed, could lead to academic, psychosocial, economic, or physical harm. The signs provide an opportunity for an early and timely preventative response that will vary in intensity. Imminent warning signs are signs of danger that require immediate and intensive interagency interventions.

Early warning signs. It is possible to recognize trouble or troubling behaviors in school-age children. It is less easy to predict that the child's behavior will lead to violence (White, Moffitt, Earls, Robins, & Silva, 1990). No single sign, or set of early warning signs, can accurately predict whether a child will be violent. Yet, for some children and youth a combination of traumatic events, history of poor behavior control, and heightened negative emotions may result in aggressive rage or violent behavior toward the self or others (Shields, Cicchetti, & Ryan, 1994).

Children who become violent toward self or others frequently report feeling rejected and psychologically victimized (Guerra, Huesmann, Tolan, Van Acker, & Eron, 1995). Young children who respond aggressively, striking out at others early in life, may be in greater danger of becoming progressively more violent (Olweus, 1980; Walker, Colvin, & Ramsey, 1995; Walker, Steiber, & O'Neill, 1990). Those young children who engage in delinquent behavior or use drugs and alcohol before age 12 are most at risk when not afforded early, effective, intensive, and sustained interventions (Walker, Steiber, & O'Neill, 1990).

The early warning signs noted in *Early Warning, Timely Response: A Guide to Safe Schools* include: (a) social withdrawal; (b) excessive feelings of isolation and being alone; (c) excessive feelings of rejection; (d) being a victim of violence; (e) feelings of being picked on and persecuted; (f) low school interest and poor academic performance; (g) expression of violence in writings and drawings; (h) uncontrolled anger; (i) patterns of impulsive and chronic hitting, intimidating, and bullying behaviors; (j) history of discipline problems; (k) past history of violent and aggressive behavior; (l) intolerance for differences and prejudicial attitudes; (m) drug use and alcohol use; (n) affiliation with gangs; (o) inappropriate access to, possession of, and use of firearms; and (p) threats of violence. These signs are not equally weighted nor are they listed in any order of significance (Dwyer et al., 1998). As emphasized in the *Early Warning Guide*, these signs indicate that a child is in distress, but is not necessarily violent.

While violence cannot be easily predicted, students often exhibit warning signs that indicate the need for school staff and family to examine if the child requires intervention. Sustained school and family-focused interventions, such as providing behavioral supports, skill training, and making meaningful connections to a consistent adult mentor can effect positive change (Eccles et al., 1993; Werner, 1993). The complexity of these issues suggests that it is best to address the troubling behaviors early and, when necessary, intensively. Simplistic or single-focus solutions for intense behavioral problems will likely fail. Simple solutions such as labeling a child "emotionally disturbed" and assigning a placement in special education may relieve the system of concern, but provides little toward developing an effective intervention plan for the youth. Thus, the question is: How can school communities build their capacity to develop sophisticated and comprehensive approaches to the student problems that may lead to school violence?

Imminent warning signs. Teams must look beyond the number of signs present. Danger is signaled when the signs are connected to a progressive pattern–when depressive and angry feelings become aggressive behaviors, and overt behaviors become frequent, more serious and hostile, pointedly directed toward parents, peers, staff, or others. Youth exhibiting such a pattern of distress require immediate and multiple interventions that are of equal intensity to reduce the chance of tragedy and to ensure the safety of all parties. Interventions may include referral to law enforcement authorities and, when necessary, residential or hospital treatment. Imminent warning signs include: (a) serious physical fighting with peers or family members (Green & Donnerstein, 1983; Lemerise & Dodge, 1993; Lochman, Dunn, & Warger, 1997); (b) severe destruction of property, including fire-setting (Harris, Rice, & Quinsey, 1993); (c) severe rage for seemingly minor reasons (Keltikangas-Jaervinen, 1978); (d) detailed threats of lethal violence (Lattimore, Visher, & Linster, 1995; Tolan, Guerra, & Kendall, 1995); (e) possession and/or use of firearms and other weapons (Dwyer, 1999b); and (f) other self-injurious behaviors or threats of suicide (Hillbrand, 1995).

When a child or youth informs others of a detailed plan (i.e., one that includes time, place, and method) to harm or kill others, a professional (e.g., school psychologist or other mental health professional) should immediately interview that child. A history of aggression or attempts to carry out threats in the past may increase the level of imminent danger. Working with others, including the family and other professionals, an immediate intervention plan should be prepared for acute intervention to ensure safety and security and to intervene therapeutically. Possession of a weapon, particularly a firearm, requires contact with law enforcement. Weapon possession, in combination with other imminent signs, requires immediate, multiple interventions in addition to the required law enforcement referral under federal or state statute. It would be the exception for the school to *not* involve appropriate community agencies in such validated serious imminent situations. To carry out such responsibilities requires that each school system have in place effective, crisis-response linkages with community mental health, child service, and law enforcement agencies. In all situations in which students present validated threatening behaviors, *parents should be informed of the concerns immediately.*

Designing and Implementing Program Components

Strategic planning requires keeping the vision in mind and establishing goals and objectives that bring the school closer to that vision. Developing the plan will include selecting proven practices and integrating those strategies into the comprehensive plan.

Select Prevention and Intervention Programs

Selecting programs requires careful considerations as to feasibility and costs. No strategy should be selected for implementation unless there is evidence that it has been demonstrated to work in a setting similar to your own. Criteria to consider when selecting programs should include: rigorous experimental or quasi-experimental design, significant effect on reducing risk factors and/or increasing academic success, replication in schools, and sustained positive results. Effective programs specify goals and objectives, determine the barriers that must be overcome to realize these objectives, identify strategies for overcoming these barriers and realizing these objectives, and delineate procedures for determining whether an objective is being realized. These procedures must include midcourse reviews to check whether the program is on course.

The Center for Effective Collaboration and Practice of the American Institutes for Research has developed additional criteria for selecting interventions (Dwyer, Jackson, Osher, & Rodi, in press). These criteria include: (a) cultural and family-friendly, (b) flexibility of implementation, (c) available manual and technical assistance, (d) record of school implementations, and (e) identified critical components. Agreement is required for selecting culturally and family-friendly interventions that are also proven or promising. The team must have some assurance that the interventions will be implemented as intended and evaluated as to their effect on children and families. It is important to note that it may take a full year to develop a plan and implementation strategy.

Identify Effective Programs

It is critical for schools to examine the array of available lists of exemplary, proven, and promising programs. While a complete list of such programs is beyond the scope of this chapter, several published lists of proven programs are available through federal agencies such as the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; Safe and Drug Free Schools, Office of Special Education Programs, U.S. Department of Education; National Association of School Psychologists; National Prevention Coalition, National Mental Health Association; and the Center for Effective Collaboration and Practices, American Institutes for Research; among others. There are also guides to help schools select their programs (Wald, Schwartz, & Saunders, 2001). Each compendium of programs has more than 30 interventions that can be integrated to provide a comprehensive prevention-intervention plan.

The implementation of specific strategies has implications for other possible programs. Specifying how the strategies are interconnected and the sequence of implementation is especially valuable. It is also important to describe how your school will ensure a foundation that is responsive to student needs and provides a base for implementing prevention and intervention programs. The implementation plan should include a description of how the school community will become knowledgeable about the early and imminent warning signs of violence as well as a description of the comprehensive program.

Delineate a Step-By-Step Plan

The core team should prepare a step-by-step plan to share with the school-community team and administration for consensus approval. Specifics of this plan will include implementation activities, timelines, people responsible, resources, training, and evaluation strategies. For example, plans for a program modification may be implemented over a short time with little additional resources whereas a totally new intervention or significant service overhaul may require two to five years and shifting significant resources to implement and evaluate. Remember, for change to be effective, it must be systemic. Marginal change will fail to address the complex problems of learning and behavior. Finally, all effective changes are implemented locally and must be modified to fit the community at the same time that they replicate proven practices (Dwyer, 1999a).

Review the Prevention and Intervention Plan

Once you have prepared your plan, check it against the effective characteristics of schools (see Figure 2, on page 32). Seek feedback from a variety of sources by circulating drafts and explaining how the plan will result in the intended outcomes. Be clear on how the interventions will be integrated into existing and other education reforms. Identify the expectations and roles of all involved, including partner agencies, families, and students. Most plans will require both human and fiscal resources to fully implement. It is critical to have administrative support for a multiyear budget before initiating and publicizing the interventions or training.

Implement the Plan

If your planning team maintained buy-in of administrators and those who will implement the plan throughout the planning process, then you are probably ready to begin training and retraining. Implementation of the plan requires a long-term commitment. Most likely, it will take several years to have all components of the plan in full operation. The important thing is to set a reasonable timeline for implementation and reaching the goals and objectives.

Training is frequently an early implementation step. It is important that the training is sufficient and that all persons who need to be trained are included. For example, when implementing any social skills, bully prevention, or problem-solving instructional program, all staff (including bus drivers and crossing guards) needs to have appropriate training. Providing training to families has always been shown to increase the effect of a good curriculum (Tolan & Guerra, 1994). Training that involves group instruction, opportunities for observed practice, modeling, coaching, and monitoring can also be effective. Specific staff responsible for early interventions may need more intensive training and skill development in interagency coordination with family support providers. Intensive interventions that are most frequently provided by clinical personnel may require somewhat expensive training by certified trainers, followed by direct supervision.

The team should ensure that every member of the greater school community accepts and adopts the violence-prevention and response plan. This buy-in is essential if all members of the school community are expected to feel comfortable sharing concerns about children who appear troubled. Too often, caring individuals remain silent because they have no way to express their concerns.

Establish Evaluation Procedures

Evaluation is a critical component of the comprehensive school plan. It is important that goals, outcomes, and evaluation measures are predetermined. It may be valuable for the school or system to secure a cooperative relationship with a local university to assist in establishing realistic, but effective, evaluation tools and methods. Many programs examine the acceptability, integrity, and effectiveness of their interventions. In measuring effectiveness, many have used their baseline data to establish goals and have determined targets related to those data for each variable. Both summative and formative evaluations are needed to allow for midcourse adjustments. When ongoing evaluations result in significant modifications of the plan, or other factors make it necessary to change or modify the plan, it is critical that the stakeholders involved in developing the plan are included in or informed of the changes. To maintain trust and community support, the school team should not significantly modify prevention and intervention plans without ensuring communication and involvement.

The school should be responsible for the evaluation of its prevention and intervention programs and should provide reports on a regular basis, possibly quarterly. The expanded school-community team and other administrative stakeholders should be supported in monitoring the progress of the plan on an annual basis. Once the interventions are in place, and progress is being made, it is critical to share the information with the greater community to best ensure sustainability. It is important to give the administration the opportunity to promote any positive effects of the interventions.

Summary

It is critical that all children be included in the goals of education. Educational professionals may promote competence through early and appropriate strategies for all children who show a lack of academic and behavioral growth. Preventing school failure also prevents frustration, self-doubt, and shame, all of which can lead to alienation and risk for involvement with the criminal justice system and other negative outcomes. Children who are exposed to multiple risk factors in early childhood have an increased chance for later-life difficulties, including criminal and violent behaviors (Cairns & Cairns, 1994). The influence of risk factors, however, can be countered by *protective factors* such as school-community intervention programs that address the strengths and needs of each child (Kazdin, 1993).

Safe, effective, and responsive schools promote competence and reduce violence by planning and ensuring that children receive the instructional and psychosocial supports that enable all students to succeed both academically and behaviorally (Haynes & Comer, 1993, 1996). They emphasize teaching *all* children by individualizing instruction to account for the unique needs and cultural differences of *each* child, including those with disabilities, and by remediating early academic and behavioral deficits. Finally, responsive schools respect diversity and teach tolerance. Effective schools support training for cultural competence and develop and use curriculum and regulations that reduce potential bias.

Once a school has examined its responsiveness, effectiveness, and safety, it can move on to determine what additional schoolwide interventions are needed to ensure that it is providing prevention programs necessary to proactively address the psychosocial development of all children. This effort includes teaching appropriate behaviors and social problem solving. When choosing a curriculum or program for this purpose, the school should select a program that has proven results with the age and ethnicity groups that match those of your school. Other issues to address include the availability of training materials, staffing considerations, and costs for schoolwide implementation.

Research has documented a number of early intervention strategies that are effective in meeting the behavioral and academic needs of students with or at risk of developing behavior problems. For example, children from high-risk environments can overcome adversity when they have the opportunity to develop a positive relationship with an adult who sustains that mentoring relationship (Blum & Rinehart, 1998; Epstein, 1994; Furtwengler, 1996; Garmezy, 1993; Werner & Smith, 1992). Furthermore, youth participation in extracurricular and other supervised, extended-day activities in school also can increase positive outcomes and possibly reverse the trajectory toward crime and violence (Walker et al., 1995). Safe, effective, and responsive schools provide a climate in which children can discuss their personal concerns and the concerns they have about friends, intimidation, bullying, and stress. Connecting with trained and caring adult staff may be one of the more powerful factors in facilitating resiliency (Bodine, Crawford, & Schrumpf, 1995; Kazdin, 1993).

The *Early Warning Guide* (Dwyer et al., 1998) and *Action Guide* (Dwyer & Osher, 2000) provide a blueprint for schools to use to better address the environmental and behavioral factors that can lead to violence. Educators, school psychologists and related professionals, families, students, agencies, faith leaders, business leaders, and policymakers must seek a role in ensuring caring, prosocial, safe, effective, and responsive schools and communities. The blueprint provided by the *Guides* cannot fit every community without local modifications. The community must also provide the local designers and builders (team) with the permits (laws and policies) and materials (resources) to construct a structure that serves the needs of the children and families in that community. The structure must be accessible as well as evaluated regularly and, when necessary, modified to continue its effectiveness. Resources must also be available to maintain the structure for several years to prevent deterioration. Children and families deserve no less. Building and maintaining safe, effective, and responsive school communities is the keystone to facilitating the educational success of all students.

References

Adelman, H. S. (1996). Restructuring education support services and integrating community resources: Beyond the full service school model. *School Psychology Review, 25*, 431-445.

Adelman, H. S., & Taylor, L. (1998). Mental health in schools: Moving forward. *School Psychology Review, 27*, 175-190.

Allensworth, D., Lawson, E., Nicholson, L., & Wyche, J. (1997). *Schools and health: Our nation's investment*. Washington, DC: National Academy Press.

American Institutes for Research. (2000). *An educators' guide to school-wide reform*. Washington, DC: Author.

Batsche, G. M., & Knoff, H. M. (1994). Bullies and their victims: Understanding a pervasive problem in the schools. *School Psychology Review, 23*, 165-174.

Batsche, G. M., & Knoff, H. M. (1995). Best practices in linking assessment to intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 569-586). Washington, DC: National Association of School Psychologists.

Blum, R. W., & Rinehart, P. M. (1998). *Reducing the risk: Connections that make a difference in the lives of youth*. Minneapolis, MN: University of Minnesota Press.

Bodine, R. J., Crawford, D. K., & Schrumpf, F. (1995). *Creating the peaceable school: A comprehensive program for teaching conflict resolution*. Champaign, IL: Research Press.

Cairns, R., & Cairns, B. (1994). *Lifelines and risks: Pathways of youth in our time*. Cambridge: Cambridge University Press.

California Department of Education. (2001). *California healthy kids survey*. Sacramento, CA: Author. Available Online: www.wested.org/hks

Colvin, G., Kameenui, E., & Sugai, G. (1993). Reconceptualizing behavior management and school-wide discipline in general education. *Education and Treatment of Children, 16*, 361-381.

Colvin, G., Sugai, G., & Kameenui, E. (1993). *Proactive school-wide discipline: Implementation manual*. Eugene, OR: Project PREPARE, Behavioral Research and Teaching, College of Education, University of Oregon.

Cornell, D. G. (1998). *Designing safer schools for Virginia: A guide to keeping students safe from violence*. Charlottesville, VA: University of Virginia, Thomas Jefferson Center for Educational Design.

Crowe, T. D. (1990, fall). Designing safer schools. *School Safety*, pp. 9-13.

Curtis, M. J., & Stollar, S. A. (1995). System-level consultation and organizational change. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 51-58). Washington, DC: National Association of School Psychologists.

Dwyer, K. P. (1999a). Implementing IDEA '97: An historical perspective. NASP *Communiqué, 28*(4), 2.

Dwyer, K. P. (1999b). Building safe and supportive schools for all children. *Family Matters*. Washington, DC: National Resource Network for Child and Family Mental Health Services, Washington Business Group on Health.

Dwyer, K. P. (2001, June). *Safe schools, healthy students*. Paper presented at the annual meeting of the National Mental Health Association, Washington, DC.

Dwyer, K. P., Jackson, S., Osher, D., & Rodi, M. (in press). *Implementation Guide.* Washington, DC: American Institutes for Research.

Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide.* Washington DC: U.S. Departments of Education and Justice, American Institutes for Research.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools.* Washington, DC: U.S. Department of Education.

Eccles, J. S., Midgley, C., Wigfield, A., Buchanan, C. M., Reuman, D., Flanagan, C., & MacIver, D. (1993). The impact of stage-environment fit on young adolescent's experiences in schools & families. *American Psychologist, 48,* 90-101.

Elias, M. J., Zins, J. E., Weissberg, R. P., Frey, K. S., Greenberg, M. T., Haynes, N. M., Kessler, R., Schwab-Stone, M. E., & Shriver, T. P. (1997). *Promoting social and emotional learning guidelines for educators.* Alexandria, VA: Association for Supervision and Curriculum Development.

Epstein, J. L. (1994). Theory to practice: School partnerships lead to school improvement and student success. In C. L. Fagnano & K. N. Hughes (Eds.), *School, family, and community interaction: A view from the firing lines* (pp. 39-54). Boulder, CO: Westview Press.

Furlong, M., & Morrison, G. (1994). School violence and safety in perspective. *School Psychology Review, 23,* 139-150.

Fullen, M. G., & Stielgelbauer, S. (1991). *The new meaning of educational change.* New York: Teachers College, Columbia University.

Furtwengler, W. J. (1996). Improving secondary school discipline by involving students in the process. *NASSP Bulletin, 80,* 36-44.

Garmezy, N. (1993). Children in poverty: Resilience despite risk. *Psychiatry: Inter-personal and biological processes, 56,* 127-136.

Gottfredson, G. D., & Gottfredson, D. C. (1985). *Victimization in schools.* New York: Plenum.

Gottfredson, D. C., Gottfredson, G. D., & Hybl, L. G. (1993). Managing adolescent behavior: A multiyear, multi-school study. *American Educational Research Journal, 30,* 179-215.

Green, R. G., & Donnerstein, E. I. (1983). *Aggression: Theoretical and empirical reviews.* New York: Harcourt-Brace.

Greenberg, M. T., Zins, J. E., Elias, M. J., Weissberg, R. P. (in press). School-based prevention: Promoting positive youth development through social and emotional learning. *American Psychologist.*

Guerra, N. G., Huesmann, L. R., Tolan, P. H., Van Acker, R., & Eron, L. D. (1995). Stressful events and individual beliefs as correlates of economic disadvantage and aggression among urban children. *Journal of Consulting and Clinical Psychology, 63,* 518-528.

Haller, E. J. (1992). High school size and student in discipline: Another aspect of the school consolidation issue? *Educational Evaluation and Policy Analysis, 14,* 145-156.

Harris, G. T., Rice, M. E., & Quinsey, V. C. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior, 20,* 315-335.

Hawkins, J. D., & Catalano, R. F. (Eds.). (1992). *Communities that care: Actions for drug abuse prevention*. San Francisco: Jossey-Bass.

Hawkins, J. D., & Weis, J. G. (1985). The social development model: An integrated approach to delinquency prevention. *Journal of Primary Prevention*, *6*, 73-97.

Haynes, N. M., & Comer, J. P. (1993). The Yale school development program: Process outcomes and policy implications. *Urban Education*, *28*, 166-199.

Haynes, N. M., & Comer, J. P. (1996). Integrating schools, families, and communities through successful school reform: The school development program. *School Psychology Review*, *25*, 501-506.

Hillbrand, M. (1995). Aggression against self and aggression against others in violent psychiatric patients. *Journal of Consulting and Clinical Psychology*, *63*, 668-671.

Hoagwood, K., & Erwin, H. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies*, *6*, 435-451.

Hunter, L., & Elias, M., (1998). School violence: Prevalence, policies, and prevention. In A. R. Roberts (Ed.), *Juvenile justice: Policies, programs, and services* (pp. 71-92). Chicago: Nelson-Hall.

Hyman, I. A., & Perone, D.C. (1998). The other side of school violence: Educator policies and practices that may contribute to student misbehavior. *Journal of School Psychology*, *30*, 7-27.

Kazdin, A. E. (1993). Adolescent mental health. *American Psychologist*, *48*, 127-141.

Keltikangas-Jaervinen, L. (1978). Personality of violent offenders and suicidal individuals. *Psychiatria Fennica*, pp. 57-63.

Knoff, H. M. (1996). The interface of school, community and health care reform: Organizational directions toward effective services for children and youth. *School Psychology Review*, *25*, 446-464.

Knoff, H. M. (1998). *Project ACHIEVE: Training materials*. Tampa, FL: University of South Florida.

Lattimore, P. K., Visher, C. A., & Linster, R. L. (1995). Predicting rearrest for violence among serious youthful offenders. *Journal of Research in Crime and Delinquency*, *32*, 54-83.

Lemerise, E. A., & Dodge, K. A. (1993). The development of anger and hostile interactions. In M. Lewis & J. M. Haviland (Eds.), *Handbook of emotions* (pp. 537-546). New York: Guilford Press.

Lewis, T. J., Sugai, G., & Colvin, G. (1998). Reducing problem behavior through a school-wide system of effective behavioral support: Investigation of a school-wide social skills training program and contextual interventions. *School Psychology Review*, *27*, 446-459.

Lochman, J. E., Dunn, S. E., & Warger, E. E. (1997). Anger. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs: Development, problems and alternatives* (pp. 149-160). Bethesda, MD: National Association of School Psychologists.

Mortimore, P. (1995). The positive effects of schooling. In M. Rutter (Ed.), *Psychosocial disturbances in young people: Challenges for prevention* (pp. 333-363). Cambridge, MA: Cambridge University Press.

National Education Goals Panel. (2000). *Data volume for the National Education Goals Report*. Washington, DC: U.S. Government Printing Office.

Nelson, J. R. (1996). Designing schools to meet the needs of students who exhibit disruptive behavior. *Journal of Emotional and Behavioral Disorders*, 4, 147-161.

Olweus, D. (1980). Familial and temperamental determinants of aggressive behavior in adolescent boys: A causal analysis. *Developmental Psychology*, 16, 644-660.

Olweus, D. (1994). Bullying at schools: Long-term outcomes for the victims and an effective school-based intervention program. In L. R. Huessmann (Ed.), *Aggressive behavior: Current perspectives* (pp. 97-130). New York: Plenum Press.

Olweus, D. (1996). Bullying at school: Knowledge base and an effective intervention program. In C. F. Ferris & T. Grisso (Eds.), *Understanding aggressive behavior in children* (pp. 265-276). New York: New York Academy of Sciences.

Roeser, R. W. (2001). To cultivate the positive: Introduction to the special issue on schooling and mental health issues. *Journal of School Psychology*, 39, 99-110.

Roeser, R. W, & Eccles, J. S. (2000). Schooling and mental health. In M. Lewis & A. J. Sameroff (Eds.), *Handbook of developmental psychopathology* (2nd ed., pp. 135-136). New York: Plenum.

Rutherford, R. B., & Nelson, C. M. (1995). Management of aggressive and violent behavior in the schools. *Focus on Exceptional Children*, 27, 1-15.

Sheras, P. L., Cornell, D. G., & Bostain, D. S. (1996). The Virginia youth violence project: Transmitting psychological knowledge on youth violence to schools and communities. *Professional Psychology: Research and Practice*, 27, 401-406.

Shields, A. M., Cicchetti, D., & Ryan, R. M. (1994). The development of emotional and behavioral self-regulation and social competence among maltreated school-age children. *Development and Psychopathology*, 6, 57-75.

Shores, R. E., Gunter, P. L., & Jack, S. L. (1993). Classroom management strategies: Are they setting events for coercion? *Behavioral Disorders*, 18, 92-102.

Skiba, R. J., Peterson, R. L., & Williams, T. (1997). Office referrals and suspension: Disciplinary intervention in middle schools. *Education and Treatment of Children*, 20, 1-21.

Skiba, R. J., Waldron, N., Bahamonde, C., & Michalek, D. (1998, May). A four-step model for functional behavior assessment. NASP *Communiqué*, 26(7), 24-25.

Skinner, C. H., & Smith, E. S. (1992). Issues surrounding the use of self-management interventions for increasing academic performance. *School Psychology Review*, 21, 202-210.

Slavin, R. E., & Fashola, O. S. (1998). *Show me the evidence: Proven and promising programs for America's schools*. Thousand Oaks, CA: Sage.

Stephens, R. D. (1994). Planning for safer and better schools: School violence prevention and intervention strategies. *School Psychology Review*, 23, 204-215.

Tolan, P. H., & Guerra, N. G. (1994). *What works in reducing adolescent violence: An empirical review*. Boulder CO: University of Colorado, Center for the Study and Prevention of Violence.

Tolan, P., Guerra, N., & Kendall, P. C. (1995). Introduction to special section: Prediction and prevention of antisocial behavior in children and adolescents. *Journal of Consulting and Clinical Psychology*, 63, 515-517.

U.S. Department of Health and Human Services. (2001). *Youth violence: A report of the surgeon general.* Rockville, MD: USDHHS, Centers for Disease Control & Prevention, National Center for Injury Prevention & Control.

Wald, J. L., Schwartz, A., & Saunders, J. (2001). *A guide for educational personnel: Selecting an intervention or program.* Washington, DC: Elementary & Middle School Technical Assistance Center, American Institutes for Research.

Walker, H. M., Colvin, G., & Ramsey, E. (1995). *Antisocial behavior in school: Strategies and best practices.* Pacific Grove, CA: Brooks/Cole.

Walker, H. M., Steiber, S., & O'Neill, R. E. (1990). Middle school behavioral profiles of antisocial and at-risk control boys: Descriptive and predictive outcomes. *Exceptionality, 1*, 61-77.

Werner, E. E. (1993). Risk, resilience, and recovery: Perspectives from the Kauai longitudinal study. *Development and Psychopathology*, 5, 503-515.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

White, J. L., Moffitt, T. E., Earls, F., Robins, L., & Silva, P. (1990). How early can we tell? Predictors of childhood conduct disorder and adolescent delinquency. *Criminology, 28*, 507-533.

Woodruff, D. W., Osher, D., Hoffman, C. C., Gruner, A., King, M., Snow, S. T., & McIntire, J. C. (1999). The role of education in a system of care: Effectively serving children with emotional or behavioral disorders. *Systems of care: Promising practices in children's mental health, 1998 Series* (Vol. 3). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Yoshikawa, H. (1994). Prevention as cumulative protection: Effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin, 115*, 28-55.

3

危
機

Promoting School Safety[1]

Ronald Stephens, Ph.D.
National School Safety Center

> *There can be no justice until those of us who are unaffected by crime become as indignant as those who are.*
> – SOLON (*Greek philosopher, ca.* 640-559 B.C.)

Crime and violence have invaded far too many of our nation's schools. Gunfights are replacing fistfights and crisis drills are replacing fire drills. The Columbine High School tragedy introduced a new level of violence: explosive devices and random targets of violence. That single event in 1999 has forever changed the landscape of violence-prevention strategies in U.S. schools. As a result, school officials are developing closer working partnerships with law enforcement, mental health professionals, and the courts. Threats are now being taken much more seriously and there is now a greater emphasis on recognizing the early warning signs of violence (Dwyer, Osher, & Warger, 1998). In addition to efforts to recognize early warning signs, important work also has emerged regarding prevention programs to ameliorate violence.

Violent and disruptive behavior is no stranger to rural, suburban, or urban schools; nor is it confined to any socioeconomic group, cultural group, or ethnic community (National Center for Education Statistics, 1997; Nemecek, 1998). It has permeated the fabric of the U.S. school community. Moreover, nearly every school administrator who has faced a major crisis has said the same thing: "I never thought it would happen here." But violence can happen anywhere.

Several major trends related to school safety have emerged over the past few years. Those observed by the National School Safety Center (NSSC) include: (a) an expanded role in schools for the courts, probation officers, law enforcement, and other youth-serving professionals; (b) the sharing of more juvenile justice information with school administrators; (c) a significant increase in the use of tiplines through which students can report rumors and threats; (d) a greater focus on student accountability; (e) an increasing number of court cases where juveniles are prosecuted as adults for their crimes; (f) more serious behavioral problems being exhibited by young people in schools; (g) increased attention to parental liability; (h) more alternative schools and educational settings, especially at the elementary level; (i) a reduced tolerance for youth violence; (j) the use of metal detectors in schools; (k) the implementation of mandatory student uniform policies; (l) the development of safe school plans; and (m) an increasing focus on school crime prevention. These trends reflect the emerging emphasis on school safety.

In addition, school safety has become a bargaining chip among teachers' unions. For example, some teachers want background information on criminally violent students who may be enrolled in their classes. Similarly, teachers may seek feedback from the principal regarding the penalties received by students they send to the front office for discipline. In addition, many teachers are demanding better security and supervision on campus, including the development of school safety plans, as well as provisions for adding more adults to provide formal supervision of students. Nearly half of the states now require the development of safe school plans (NSSC, 2001a).

Few social causes today receive virtually unanimous support from the nation's top public policy shapers. There is, however, general agreement that reducing violence and increasing safety in U.S. schools are essential if students are to receive a high-quality education. According to Justices Lewis Powell and Sandra Day O'Connor, "Without first establishing discipline and maintaining order, teachers cannot begin to educate their students. And apart from education, the school has the obligation to protect pupils from mistreatment by other children, and also to protect teachers themselves from violence by the few students whose conduct in recent years has prompted national concern." (T.L.O. v. New Jersey, 1985).

Prevalence of School Violence

Violence in schools has touched the lives of countless students, teachers, and parents. While recent indicators have begun to show a decrease in school crime and violence in our nation's schools, the 2000-2001 school year continues to witness acts of serious violence. For example, a March 2001 shooting at Santana High School in Santee, California, left 2 students dead and 11 students and 2 adults wounded (Jimerson & Brock, 2001). The National School Safety Center (2001b) estimates that 318 violence-associated deaths have occurred on or near school campuses across the nation since 1992. Although the *number* of violent crimes on school campuses each year has decreased during recent years, the *severity* of the violence appears to be on the rise.

The data represented by classic studies, such as the Violent Schools – Safe Schools study (National Institute of Education, 1978), which served as the benchmark for school crime and violence statistics for more than two decades, have been eclipsed by recent studies. The Student Survey on Teens and Safety (Rhule, 2000) indicated that more than one-fourth of students (29%) said they do not personally feel safe from violence in the their schools. A recent national survey study of 15,877 middle and high school students reported that 39% of middle school students and 36% of high school students say they do not feel safe at school (Josephson Institute of Ethics, 2000). According to the 1999 Youth Risk Behavior Surveillance System (Centers for Disease Control and Prevention, 2000), between 2 and 16% (depending on the state in which they live) of the 15,349 high school students surveyed felt too unsafe to go to school.

Although school actually continues to be one of the safest places for our young people to be, it is difficult to convince the American public to embrace this concept. The media coverage of recent school tragedies has been so extensive and exhaustive that the tragedies tend to take on a "larger than life" factor. The public is constantly reminded of these events–when new events occur and on subsequent anniversaries of previous events. Data released in Are We Safe? The 1999 National Crime Prevention Survey (National Crime Prevention Council, 2001) indicated that 60% of U.S. adults were more concerned for their children's safety in 1999 than they were in the previous year.

The quality of a child's education can be severely affected if a child is not in a safe and welcoming learning environment. Teachers cannot teach and students cannot learn in an environment filled with fear and intimidation. Safe schools are free of crime and violence. Specifically, safe schools are secure, well supervised, drug-free, and free of gangs and weapons.

Factors Related to School Violence

A variety of factors are related to violence in schools. Several important factors are reviewed below.

Dropping Out of the Education Mainstream

For too many young people, regular school attendance and high school graduation are no longer the norm. Many youth have dropped out of the education mainstream, including (a) truants, (b) children and youths who are afraid to go to school, (c) youths who have been suspended or expelled, and (d) youths in the juvenile justice system.

Starting as early as elementary school, young people are turning away from school for a variety of reasons, including the violence in or near their schools. Other reasons include environmental factors (e.g., pregnancy and/or marriage, family health and/or financial concerns, lack of family support for an education) and school-related factors, (e.g., low math and reading scores, inability to keep up with the other students, being held back, being classified as learning disabled or emotionally handicapped, being a slow learner, verbal deficiency, lack of goals, lack of academic challenge, and teacher neglect). Each year, nearly a half million 10th- through 12th-grade students leave school without successfully completing a high school program (National Center for Education Statistics, 1994).

Truancy and dropping out are significant risk factors for delinquency and eventual adult criminality (Kirsch, Jungeblut, Jenkins, & Kolstad, 1993; Rumberger, 1987). Statistics indicate that 85% of all daytime crimes are committed by truant youths, and arrest rates for truants have been found to be 9.5 times greater than for those who regularly attend school. In addition, 75% of truant students reported that they had committed one or more common offenses during a one-year period (Levine, 1993).

The untapped potential of our young people cannot be left to chance when there exists a range of innovative and promising approaches designed to nurture each child's potential to become a contributing member of society, as well as to prevent crime and delinquency. The unemployment rate for high school dropouts is higher than for youths with a high school degree (Borus & Carpenter, 1984; Dryfoos, 1990). Dropouts often struggle to maintain a minimum standard of living, even with welfare support. To further support these findings, a report by the National Center for Education Statistics (1993) indicates that approximately 63% of dropouts were unemployed at the time of the survey. The costs of youths' dropping out of the education mainstream and failing to receive high school diplomas are too high, both for themselves and for society (Cairns & Cairns, 1994; Dryfoos, 1990; Rumberger, Ghatak, Poulos, Ritter, & Dornbusch, 1990).

Lack of Adult Supervision

Nearly 7.5 million children ages 5- to 14-years-old are on their own in the morning and afternoon before and after the school bell rings, according to a recent public policy report published by the Ewing Marion Kauffman Foundation (2000). Nearly two-thirds of school-age children are in homes with working parents. Yet very few communities have a comprehensive system of before- and after-school care for children. As a result, millions of children are on their own, especially between the hours of 3 and 8 PM, prime time for young people to engage in risky behavior. As previously described, statistics clearly show that rates of juvenile crime, drug use, and experimentation with tobacco, alcohol, and sex increase in the afternoon hours—when many children and youth are unsupervised.

A recent national study (Udry, 2000) suggests that how teenagers perform in school, and the peers they hang out with after classes, have more influence than their race or family-income level on whether they will drink alcohol, smoke cigarettes, or carry weapons. Researchers from the National Longitudinal Study of Adolescent Health (Udry, 2000) analyzed an ongoing national survey (known as the "Add Health" study) of 10,000 black, white, and Hispanic students in grades 7-12 who attended 134 schools across the country. They found that more than one of every four students surveyed (i.e., a total of 5 million students in those grades) said they had carried a gun or knife in the past year. One of every 10 students said they drank alcohol on a weekly basis. One in five 7th- and 8th-grade students said that they had sexual intercourse, while two out of three of the 11th-graders said they'd had sex. Regardless of their race or gender, students who said they had frequent problems with their schoolwork were more likely to use alcohol, smoke cigarettes, become violent, carry weapons, and attempt suicide. The study indicates that school performance—more than any other single factor—is a driving force in whether a young person becomes involved in drugs or violence. Confirming earlier studies, the researchers also found that students who spent a lot of time after school with their friends tended to be more likely to drink, smoke, have sex, and carry weapons than young people who spent their after-school hours in supervised settings.

Discipline Problems, Bullying, Hazing, and Harassment

The U.S. public has long regarded lack of discipline as the most important problem facing schools (Rose & Gallup, 2000). This should come as no surprise, since discipline problems can range from cutting classes and verbal abuse of teachers to attacks on students and robberies. Throughout the 32 editions of the Annual Phi Delta Kappa/Gallup Poll of the Public's Attitudes Toward the Public Schools, respondents have been asked to identify the most pressing educational problem with which the local public schools must deal. Lack of discipline and fighting, violence, gangs, and drugs continue to remain in the top five each year.

Schoolyard bullying is a significant and pervasive problem and is perhaps one of the most severely underrated problems within our educational system. Nearly one-third of U.S. students report they experience bullying, either as a target or as a perpetrator (Nansel et al., 2001). The survey of 15,686 public and private school students is among the first to document the prevalence of bullying in the United States. Overall, the survey found nearly 30% of the children reported that they had been involved in bullying either as a victim or as a bully. More than 16% said they had been bullied at least occasionally during the current school term and 8% reported bullying or being bullied at least once weekly. The frequency of bullying was higher among 6th- through 8th-grade students than among 9th- and 10th-grade students. Children who said they were bullied reported more loneliness and difficulty making friends, while those who did the bullying were more likely to have poor grades and to smoke and drink alcohol.

Earlier research conducted in Norway and Sweden (Olweus, 1991) estimated that one in seven students was involved in bullying (about 15%, with 6% being bullies and 9% being victims). These estimates were considered equally valid and comparable to those in the United States. Olweus suggests that bully/victim problems in school conflict with our basic values and principles. It is fundamental for a child to feel safe in school and to be spared the oppression and repeated, intentional humiliation implied in bullying. Olweus concludes that no student should be afraid of going to school for fear of being harassed or degraded, and no parent should need to worry about such things happening to his or her child.

Results of a national survey of 477 teens and 456 parents (Knowledge Network, 2000) suggest that teens' daily experiences with intimidation and physical abuse are largely ignored by both home and school. According to the poll's findings, intimidation and physical abuse are typical parts of a school day for many American teenagers. Of the 14- to 17-year-olds surveyed, more than two-thirds report that there is a group of students at their school that sometimes or frequently intimidates others, often with few or no consequences.

In a national survey of 1,500 high school juniors and seniors conducted during April 2000 by researchers from Alfred University (Hoover & Pollard, 2000), students were asked about the nature of hazing and initiation rites in American schools. The survey found that hazing is prevalent among American high school students. Of the students who belong to groups, 48% reported being subjected to hazing activities; 43% reported being subjected to humiliating activities; and 30% reported performing potentially illegal acts as part of their initiation. Hazing hurts children emotionally and physically. In the survey, 71% of the students subjected to hazing reported negative consequences, such as getting into fights; being injured; fighting with parents; doing poorly in school; hurting other people; having difficulty eating, sleeping, or concentrating; or feeling angry, confused, embarrassed, or guilty.

The serious nature of sexual harassment, another form of intimidation and humiliation once taken for granted, must be examined closely in our nation's schools, because four out of five students report having experienced some form of sexual harassment in school. Silence about sexual harassment allows abusive behavior to continue (Harris, 1993).

Drug and Alcohol Abuse

Drug traffic and substance abuse are other serious concerns for educators. Most people are not aware how truly pervasive the alcohol problem is among youths. Although illicit drugs receive most of the attention, a recent study (Centers for Disease Control and Prevention, 2000) corroborates that alcohol consumption is much more widespread than other types of substance use. According to the 1999 Youth Risk Behavior Surveillance Survey report, 50% of the student respondents had at least one drink of alcohol during the 30 days preceding the survey; 32% had 5 or more drinks of alcohol on at least one occasion during the 30 days preceding the survey. With regard to other drug usage, 27% had used marijuana and 4% had used cocaine during the 30 days preceding the survey; 15% had used inhalants and 9% had used methamphetamines during their lifetime (Centers for Disease Control and Prevention, 2000).

The Monitoring the Future Survey (Johnston, O'Malley, & Bachman, 1993) has tracked students' illicit drug use and attitudes toward drugs since 1975. The 2000 survey of drug use among 8th-, 10th-, and 12th-graders found that illicit drug use, including the use of marijuana, generally remained unchanged in the last year (National Institute on Drug Abuse, 2000). The survey marks the fourth year in a row that the use of any illicit drugs among teenagers has stayed level or declined in all categories: lifetime, past year, and past month use. The survey also found that cigarette use among teens dropped significantly, with past month use of cigarettes down from 17% to 14% among 8th-grade students and from 34% to 31% among 12th-grade students in the last year. Reductions in other categories of smoking also occurred among 8th-, 10th-, and 12th-grade students. Alcohol use, however, remained largely unchanged.

Strategies for Increasing School Safety

Comprehensive and collaborative strategies must be set in place to support the safety and success of all school children. The National School Safety Center advocates an assortment of strategies school administrators can implement now to make their campuses safer. Many of these strategies are inexpensive or cost no money at all. In many cases, the strategies will actually save money, because each strategy discourages crime and helps to foster a positive school climate (Hyman & Perone, 1998). Administrators can use these concepts as a basis for creating their own "safe school plans." Some of these strategies are described below.

Plan for Safety and Security

Place school safety on the educational agenda. When a district makes a conscious decision that safe and welcoming schools are a high priority, this commitment provides the basis for the development of plans and strategies to achieve this goal. Placing school safety on the educational agenda is a mandatory first step toward safer and better schools.

Create a mission statement. The school's mission statement should include language that reflects the context in which learning will take place. For instance, the phrase "to learn in a safe and secure environment free of violence, drugs, and fear" emphasizes the school's commitment to creating and enforcing policies that promote a safe, caring, and disciplined school climate. A statement of this nature can greatly increase the validity and credibility of school district policies that create and support a safe environment.

Make the campus safe and welcoming. School safety leadership begins at the administrative level. There is no question that the best principals spend the majority of their time outside their offices. Staying in touch cannot be accomplished behind office walls. A principal should begin the day by greeting students at the front door when they first arrive; be present in the hall during class changes; visit classrooms and attend special events; and look for other interactional opportunities to manage the campus. The way the day begins affects the climate of the entire day and has a significant impact on how it concludes.

Develop a comprehensive school safety plan. School safety must be at the top of the educational agenda not only on each campus, but also within the whole community. A districtwide safety plan should be established, complemented by a plan for each school site. Programs should be developed in collaboration with parents and students; law enforcers and the courts; probation and social service personnel; and religious, corporate, and other community leaders who represent the racial and ethnic balance of the community. Safe school planning is an ongoing process that must be interactively supported by pursuing vigorous interagency cooperation. Strategies should be established that focus not merely on security and supervision, but also on educational options, including community and corporate partnerships. Plans should be reviewed, updated, and broadly disseminated annually to students, parents, and staff members. As the planning process continues, a series of additional positive suggestions and strategies will probably emerge.

Develop Policies and Procedures for Safety

Disseminate a summary of laws pertaining to school disorder. The summary should be drafted and developed by the district's legal counsel, and disseminated through the student personnel services director or director of security to all site administrators and security personnel. This effort will ensure uniformity and consistency of student supervision and management.

Review the student handbook. The student handbook should be reviewed to ensure that expectations for student behavior are clearly communicated. School policies as stated in the handbook should reflect behavior expectations outlined in federal, state, county, and local statutes or ordinances. Policies also should be consistent with the school's educational mission statement.

Develop a clearly defined locker policy. The locker policy at each school should appropriately reflect the district's custodial interest. Students and parents should be notified that the lockers are school property. Students should be advised in the student handbook that lockers and their contents may be searched at any time for reasons of health and safety. Distributing district-owned locks to students, or requiring that students use only locks for which the school has combinations, will further enhance the school's custodial position in conducting routine locker checks.

Develop and enforce a school dress code. The behavior of students and staff tends to reflect the way they are allowed to dress. Each school district should establish a districtwide, uniform dress code policy, which establishes clear appearance standards for both students and staff. Gang attire should be prohibited, and dress code expectations should be consistently enforced. Contradictory policies and procedures, and inconsistent enforcement by staff members, send mixed messages to students. Both students and parents should be involved in developing appearance standards; they will support and preserve what they have helped create.

Review discipline and weapons possession policies. School discipline and weapons possession policies should attack the problem and not simply the symptoms. The policies should also clearly distinguish between disciplinary matters and criminal offenses. When top discipline problems have been identified, a task force consisting of students, teachers, administrators, and parents should be established to review and/or develop effective strategies and programs. Weapons policies should reflect the federal Gun-Free School Zone Act of 1994, which mandates a 12-month minimum suspension

70

for the possession of firearms. The student handbook should reflect compliance with the 1994 law. Failure to comply may result in a loss of federal funds for the district.

Inform students and parents about school rules. At the beginning of each school year, all students and their parents or guardians should be provided with written codes of conduct outlining behavioral expectations and the consequences of violating these codes. In addition to providing students and parents with comprehensive descriptions of discipline procedures and due process considerations, a one-page summary of the school rules can be developed and posted in strategic locations throughout the campus. Parents and guardians should be advised that they are expected to exercise the necessary supervision and controls upon their students' behavior to ensure that it will be conducive to the development of self-discipline and that the students' behavior will not be disruptive to the school's educational program.

Develop and enforce automobile and parking policies. Automobile and parking policies should state that campus parking is a privilege, not a right. The parking policy should also place students on notice that, when they drive their vehicles on school property, they agree to abide by campus rules and agree to have their vehicles searched. Diminishing the privacy expectation can serve as a deterrent to the presence of weapons or other contraband. The policy will also enhance the district's position for any challenges relative to search-and-seizure issues.

Establish Safety Procedures

Control campus access. Access to school grounds should be limited and supervised on a regular basis by individuals who are familiar with the student body. Continuing efforts should be made to minimize the number of campus entrance and exit points used daily. Campus traffic, both pedestrian and vehicular, should flow through areas that can be easily and naturally supervised. Parking lots often have multiple entrances and exits, and the resulting ease of access contributes to vandalism and defacement of vehicles and school property. Delivery entrances used by vendors should also be checked regularly. In addition, perimeter fencing may also be considered.

Mandate crime reporting and tracking. A uniform school crime-reporting and record-keeping system is critical to maintaining a safe and secure campus. When school administrators know what crimes are being committed on their campus, when and where crimes are committed, and who is involved, they learn volumes about what types of programs to implement and what supervision to provide. In addition, it is important to conduct some level of crime analysis, to determine what (if any) linkages exist among various aspects of criminal activity on the campus. In connection with mandated crime reporting, many administrators believe they are judged by the numbers they produce relative to school crime, suspensions, expulsions, parent complaints, and staff anxiety. Sometimes, worries about statistics and the school's image compromise accurate reporting. Steps should be taken to assure everyone that accurate reporting does not necessarily reflect bad management. If educators want others to share in the solutions, it is important to first identify the problems. Unfortunately, disruptive events generate negative publicity.

Establish an "emergency operation communications center." Such a center should utilize the latest technology and allow site administrators to make immediate contact with district school safety personnel. It should also include a school communications network, which links classrooms and schoolyard supervisors with the front office or security staff, as well as with local law enforcement and fire departments. A fully computerized public safety emergency frequency is recommended.

Establish uniform visitor-screening procedures. Specific procedures should be established to screen and monitor visitors and potential campus intruders. Signs directing persons to the office should be placed in strategic, easily visible locations, and should be large enough to attract visitors' notice. Every visitor should be required to sign in at the school office, state his or her specific business, and wear or visibly display a visitor's badge. Adults claiming to be students' custodial parents should be screened to ensure that this is the case. All school employees should be advised to greet visitors or any unidentified persons and direct them to the main office, to ensure that these persons have legitimate business at the school. Teachers and staff members should be trained to courteously challenge all visitors. "May I help you?" is a kind, nonthreatening way to begin.

Require picture identification cards for students and staff. A school administrator is responsible not only for keeping students away from trouble, but also for keeping trouble away from students. Being able to distinguish enrolled students from nonstudents and guests is critical. An effective picture identification system will enhance the control and management of the campus. Authorized parent volunteers and school visitors should also display clearly identifiable badges or name tags.

Establish two-way communication between the front office and each classroom. Campus communications systems should include two-way communication capability between each classroom and the office. Teachers should be able to contact the front office from any classroom. Campus supervisors, assistant principals, and principals should also have two-way radios. The campus should have at least one such radio with cellular phone capability and a private unlisted number for use in emergency situations. Detention classrooms or facilities for behaviorally disruptive students should have emergency buzzers or call buttons.

Limit opportunities to transport and store weapons and other contraband. School systems around the country have implemented a variety of policies to prevent contraband from being brought to school. These policies include: (a) allowing only clear plastic or mesh book bags, or no book bags at all; (b) eliminating lockers completely; (c) establishing a checking area for coats and jackets and requiring large articles of clothing capable of shielding contraband to be left there rather than worn or carried into other areas; (d) providing students with two sets of textbooks, one for home and one at school, to eliminate the need for book bags at school (eliminating the potential costs of a full-scale, five-day-a-week, every-student search would save enough money to justify using this approach); and (e) reducing the amount of time between class changes, as well as extending the length of class instructional periods, so that students will not have to make so many class changes.

Use current technologies that promote crime prevention. Numerous options are now available for improving access control, property identification, and ongoing supervision. For example, electromagnetic door-locking systems with intrusion alarms should perhaps be considered. Property control strategies such as microdot systems, surveillance cameras for difficult-to-supervise public areas, and other high-tech strategies may also be appropriate to a particular educational setting.

Modify the Environment

Promote crime prevention through environmental modifications. School crime and violence are often unwittingly promoted by the way facilities are designed, managed, or maintained. Making modifications to these facilities can produce positive change. Some modifications include: (a) trimming or removing shrubbery that interferes with natural surveillance; (b) providing maximum supervision in heavy traffic areas; (c) providing strategically located public telephones with dial-free connections to emergency services; (d) relocating safe activities near typical trouble spots (e.g., relocating a counselor's office next to a corridor or locker bay where problems have occurred); (e) conducting ticket sales or concession activities in or near problem areas; (f) eliminating obstacles (such as trash cans and architectural barriers) that not only block or impede traffic flow, but also hinder supervision and surveillance; (g) installing parabolic/convex mirrors in stairwells and other locations that require improved supervision; (h) replacing double-entry restroom doors with an open zigzag design, to permit better monitoring of behavior in restroom areas; and (i) utilizing automatic flush valves and automatic water faucets in restrooms to reduce vandalism and control water consumption.

Develop a nuisance abatement and community clean-up program. School officials must work closely with police and community leaders to shut down drug houses and stop illegal group activities in the neighborhoods of schools. The local U.S. attorney's office, and city and county officials, are excellent resources to cultivate. Their support is critical as local and regional gang, drug, and graffiti abatement strategies are developed. School officials should work with the local community in seeking cooperative solutions to nuisance abatement problems, including protecting the school site and ensuring that the walk to school is crime-free and nonthreatening.

Collaborate With Agencies, Staff, and Students

Provide adequate adult supervision. Young people need continual, responsible supervision, which may include teachers, administrators, parents, campus supervisors, or law enforcement officers. By all means, senior citizens should not be forgotten; just as many young people are looking around for something to do, many senior citizens are around whose talents and resources have yet to be tapped. For the most part, recent studies have shown that the majority of young people believe that adults can play a major role in counseling them and encouraging them toward nonviolence.

Establish a school peace officer training program. School peace officers should be academy-trained and/or certified as having received Police Officer Standards Training. Their training and their compensation should be commensurate with their responsibilities, and consistent with that offered by local law enforcement agencies. This will elevate the preparation and capability of school personnel to meet the specific needs demanded by their position. The professional training required of school security officers today is dramatically different from that of 25 years ago. School security officers must continually take part in special services and in-service training programs to stay abreast of innovative methods and techniques. Officers can enhance their professional status by participating in such professional organizations as the National Association of School Resource Officers or the International Association of School Safety Professionals. Some of the most effective school peace officer programs bring officers into contact with children in the early grades, and allow the officers to follow the students through elementary, middle, and high school. School peace officers can do some of their best work once they get to know the children.

Develop a student crime prevention program. A school crime watch program can be established with the aid of such groups as Crimestoppers International (2001), the National Crime Prevention Council's Youth Crime Watch, Neighborhood Crime Watch, Block Watch, and other related programs (National Crime Prevention Council, 2001). Financial incentives can also be provided for individuals who report crimes.

Work with local law enforcement officials. Schools may develop a "joint powers agreement" or "memorandum of understanding" describing how campus criminal offenses will be managed. This includes such matters as mandated crime reporting for weapons or drug offenses, information-sharing relative to criminal offenses, law enforcement responsibilities during a hostage situation, officers' presence on the campus (in uniform or out of uniform), where to conduct investigative interviews, managing special events, as well as a host of other school law enforcement matters.

Consistently enforce information-sharing agreements. At least once annually, school administrators should review their information-sharing agreements to ensure that they are in compliance with federal and state laws and to ensure that school administrators and education staff are doing everything possible to share such information with those who have a legitimate need to know. The courts should also make efforts to ensure that court orders and other information-sharing agreements among agencies are being carried out in compliance with court guidelines, so that children can be better served. The student record policy should state that student records may be shared with any relevant teacher, staff member, or other youth-serving professional who has a legitimate need to know.

Place a probation officer on campus. In some schools, a probation officer can be placed on campus to provide more intensive supervision for students on probation who attend school. Exercising such an option can complement the efforts of school personnel, who can then invest more time in reinforcing the positive behavior of other students, rather than simply in disciplining troublemakers.

Enhance interagency cooperation among youth-serving professionals. Creating safe schools is a community function; educators cannot do it alone. Thus, educators must cooperate actively with community agencies. Campus security operations should be coordinated with local law enforcement agencies. Community support agencies—such as the county mental health department, child protective services, the social services department, the department of parks and recreation, the juvenile probation system, and the courts—must actively work with schools to identify students who are potentially dangerous, and to provide services to preclude these students from causing further problems and assist them in their educational and personal development. Through such cooperation, effective education and behavior plans can be developed to better protect the rights of students and staff members while rehabilitating juvenile offenders. As needs and interests dictate, consider placing representatives from youth and family agencies on the school campus to better provide student support and services.

Promote Student Support and Involvement

Incorporate life skills curricula. Young people need to learn how to deal with conflict in nonviolent ways. School violence is the tangible expression of unresolved conflict. If we can help children and youths identify and implement constructive conflict resolution techniques, we can make our campuses much safer. A curriculum that emphasizes courtesy and thoughtfulness will go a long way toward creating a more positive and effective campus life. Programs that focus on good decision making, responsible citizenship, and conflict resolution can enhance school safety.

Encourage active student involvement. Students should be actively involved in their own safety and in safety planning, including learning conflict resolution techniques (see below). They should also be involved in planning and managing student events and programs and in campus maintenance and beautification projects. Student participation not only promotes responsible development and maturity; it also enables students to be part of the solution rather than part of the problem.

Implement peer counseling and peer mediation programs. Again, students represent some of the best agents for promoting and maintaining a safe and secure campus. An effective peer-counseling program can head off many problems before they reach explosive and violent levels. In addition, the students who are trained as peer counselors become wonderfully influential resources for nonviolent problem solving.

Create a climate of ownership and school pride. Every student and staff member should feel like a key part of the school community. This can be accomplished by involving every person in the school safety planning process, including students, parents, teachers, and community leaders. If they are not in place already, homeroom areas should be established for faculty and students. School-sponsored groups and clubs can be encouraged to take ownership of specific hallways, display areas, or other locations.

Establish a variety of extracurricular programs. School children need positive things to do. Without interesting, positive, or challenging activities, students tend to fill the void with negative activities. A safe school provides students with several options, before, after, and during school. Inherent within this strategy is the expectation that all indoor and outdoor athletic equipment will be properly maintained.

Implement Crisis and Safe School Planning and Evaluation

Establish a crisis response plan. Many potential problems can be avoided through responsible planning. Sometimes, however, a crisis is unavoidable. A good crisis plan focuses on crisis prevention, preparation, management, and resolution. It also identifies community resources and agencies that serve students. The crisis response plan should include step-by-step procedures for all possible types of crisis situations (e.g., assault and battery, intruders, bomb threats, campus unrest, and natural disasters).

Identify specifically assigned roles and responsibilities. Specific policies and procedures that detail staff members' responsibilities for security should be developed. These responsibilities may include monitoring hallways and restrooms, patrolling parking lots, and providing supervision at before-school and after-school activities.

Conduct an annual review. Every school should conduct an annual school safety assessment and review, because planning for a safe school is an ongoing process. The evaluation component is a continuing reality check, and it allows for refinement of the actions and attitudes that a safe school wishes to create and maintain. The assessment may reveal that additional steps should be taken to improve adult supervision, revise curricula, encourage new legislation, redesign facilities, or establish new programs.

Identify and Deal With Troubled Youth

Provide options and support services for troubled youth. It is important for the central administration to expand the network of alternative placement options for troubled youths. Weapon-using or weapon-toting youngsters should be removed from the mainstream educational setting and relocated at alternate sites where closer supervision and greater structure are provided such that youth receive appropriate support and assistance.

Establish a restitution and community service program. Educators should work with the presiding juvenile judge and the chief probation officer to establish a series of community service and restitution programs at their schools. Individuals who are involved in vandalism and acts of malicious mischief should have some positive means of making amends to their victims and to the larger society for their infractions and offenses. Opportunities for service should be developed in cooperation with relevant governmental and community agencies.

Create sanctions for provocative behavior. "Hard looks," "stare-downs," and "mad-dogging" should be added as actionable offenses to the student code of conduct. Such behavior should not be tolerated.

Address bullying behaviors. Establishing support policies and support services for both victims and perpetrators of bullying behaviors is essential. All students involved in such activities should receive appropriate support and assistance to facilitate positive adaptation and avoid harmful outcomes associated with bullying (as described above).

Address fear of violence. The fear of violence can send a wave of concern and intimidation through a school and should be addressed with the same level of seriousness as actual campus violence. Just as dealing with actual school violence requires several unique strategies, dealing with fear requires several compelling actions. These actions include meeting with students and staff members to assess and understand their concerns; creating broad-based task forces to develop appropriate strategies; providing counselors and other adults to talk with and supervise young people; and having open discussions with local community and business representatives.

Create a student tipline. Despite all the high-tech strategies for safe schools, students continue to be the best metal detectors and the most effective rumor control agents. It is important for school officials to work with students to encourage them to break the "code of silence" when it comes to sharing concerns over guns, threats, and potential violence.

Develop a "Threat Assessment Protocol." School administrators cannot be expected to be omniscient. However, the school administrator can develop good crime prevention savvy by establishing a closer working partnership with mental health professionals and local law enforcement when it comes to handling threat assessments. All threats should be taken seriously and should be carefully evaluated.

Identify and track repeat offenders. The majority of school crime problems are caused by a small percentage of students. It is essential to track, monitor, and closely supervise these youngsters, to discourage their continued involvement in misbehavior and crime. The following actions should be considered when planning such close supervision: (a) placing students with experienced teachers, (b) developing individual behavior and education plans, (c) having the students and their parents/guardians sign behavior contracts, (d) consistently enforcing and fairly applying the rules, (e) assigning a specific counselor to each student, and (f) assigning these students lockers located in areas that are visible and easily supervised. Students with numerous offenses should be given in-school suspensions or placed in alternative education programs within the district; troublemakers should not be rewarded with more time off from school or lighter class schedules.

Develop Effective Screening and Training Programs

Carefully screen and select new employees. One of the most important decisions that educators make on behalf of parents and communities is deciding who will teach, train, coach, counsel, and lead their children. Keeping child molesters and pedophiles out of schools and other youth-serving organizations is a major task. Every school system and youth-serving organization should have clear policy guidelines and procedures to weed out individuals with a criminal background of misbehavior involving children. Any record-screening program must consider the rights of privacy and due process, as well as the individual's right to a hearing when disqualification is involved. The screening program must also weigh these rights against the rights of the young people with whom the job seeker will come into contact. In addition, some school systems and youth service organizations have already faced multimillion-dollar lawsuits for their failure to screen, properly supervise, and/or remove employees who constituted a risk to children.

Promote cultural fluency. The unique worth of every person in a school should be emphasized. The polarization of student groups and of gangs on many campuses indicates a need to develop educational programs and activities that bring students together. Such a desirable result may be brought about by using a multicultural curriculum or by instituting a process of cooperative learning. Bringing students together to work collaboratively on specific projects can pay great dividends.

Conduct annual school safety training programs. Prior to the start of each school year, training sessions should be held for all site administrators and security personnel to review school safety procedures and strategies. School staff members should be informed and regularly updated on safety plans through in-service training. The training should include all faculty and staff, including part-time and substitute employees.

Provide teacher-training programs. Special in-house training programs in the area of student behavior management should be offered for teachers and administrators. Strategies that worked years ago may no longer be effective. Teachers must develop coping skills and techniques for controlling classroom behavior and dealing with disruptive youths and angry parents. Such skill building and training are necessary to ensure teachers' educational effectiveness, as well as their personal safety.

In Summary

The success of efforts to enhance school safety is contingent on the presence of eight key factors, which must operate in and through the strategies presented in this chapter. These factors include (a) establishing clear behavior standards; (b) providing adequate adult presence, supervision, and involvement; (c) enforcing rules fairly and consistently; (d) closely supervising and consistently sanctioning offenders; (e) getting parents on the school's side; (f) making the school physically safer; (g) creating partnerships with outside agencies; and (h) believing that the school can make a difference. The strategies outlined in this chapter represent the beginning of a continuing collaborative process to create safe schools for all U.S. children and youths. Finally, making schools safe requires an ongoing commitment to the skilled and continuing implementation of such strategies.

References

Borus, M., & Carpenter, S. (1984). Choices in education. In M. E. Borus (Ed.), *Youth and the labor market* (pp. 81-110). Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.

Cairns, R., & Cairns, B. (1994). *Lifelines and risks: Pathways of youth in our time.* Cambridge: Cambridge University Press.

Centers for Disease Control and Prevention. (2000). *1999 Youth Risk Behavior Surveillance System.* Available Online: www.cdc.gov/mmwr/preview/mmwrhtml/ss4905a1.htm

Crimestoppers International. (2001). *Information and overview.* Available Online: www.c-s-i.org/index2.html

Dryfoos, J. (1990). *Adolescents at risk: Prevalence and prevention.* New York: Oxford University Press.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools.* Washington, DC: U.S. Department of Education.

Ewing Marion Kauffman Foundation. (2000). *When school is out.* Available Online: www.emkf.org

Harris, L. (1993). *Hostile hallways: The AAUW survey on sexual harassment in America's schools.* Washington, DC: American Association of University Women Educational Foundation.

Hoover, N. C., & Pollard, N. J. (2000). *Initiation rites in American high schools: A national survey.* Available Online: www.alfred.edu/news/index.cfm

Hyman, I. A., & Perone, D. C. (1998). The other side of school violence: Educator policies and practices that may contribute to student misbehavior. *Journal of School Psychology, 36*, 7-27.

Jimerson, S. R., & Brock, S. E. (2001, April). NASP/CASP response following shootings on school campuses. NASP *Communiqué, 29(6)*, 7.

Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (1993). *National survey results on drug use from monitoring the future study, 1975-1992 (Vol. 1).* Rockville, MD: National Institute on Drug Abuse.

Josephson Institute of Ethics. (2000). *Report card on the ethics of American youth 2000 report no. 1: Violence, guns and alcohol.* Available Online: www.charactercounts.org

Kirsch, I., Jungeblut, A., Jenkins, L., & Kolstad, A. (1993). *Adult literacy in America: A first look at the results of the national adult literacy survey.* Report prepared by Educational Testing Service with the National Center for Education Statistics, U.S. Department of Education. Washington, DC: U.S. Government Printing Office.

Knowledge Network. (2000). *Empowerment Program.* Available Online: www.empowered.org

Levine, B. (1993, August 16). Tracking truants. *Los Angeles Times*, p. C7.

Nansel, T. R., Overpeck, M., Pilla, R. S., Ruan, W. J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among U.S. youth: Prevalence and association with psychosocial adjustment. *Journal of the American Medical Association, 285*, 2131-2132.

National Center for Education Statistics. (1993). *Youth Indicators 1993.* Washington, DC: U.S. Government Printing Office, U.S. Department of Education.

National Center for Education Statistics. (1994). *Drop out rates in the United States.* Washington DC: U.S .Government Printing Office, U.S. Department of Education.

National Center for Education Statistics. (1997). *Statistics in brief: Student victimization at school.* Washington, DC: U.S. Department of Education.

National Crime Prevention Council. (2001). *Making children, families, and communities safer from violence.* Washington, DC: Author. Available Online: www.ncpc.org/2safer.htm.

National Institute on Drug Abuse. (2000, December). *Monitoring the Future Survey, the University of Michigan's Institute for Social Research.* Washington, DC: National Institutes of Health.

National Institute of Education. (1978). *Violent schools—safe schools.* Washington, DC: Author.

National School Safety Center. (2001a). *Report on violence in the schools.* Westlake Village, CA: Author.

National School Safety Center. (2001b). *School associated violent death report.* Westlake Village, CA: Author. Available Online: www.nssc1.org

Nemecek, S. (1998). Forestalling violence: American youths are suffering an epidemic of violence, both in and out of the classroom. *Scientific American, 279,* 15-26.

Olweus, D. (1991). Bully / victim problems among school children. Basic facts and effects of a school based intervention program. In D. J. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 411-455). Hillsdale, NJ: Lawrence Erlbaum.

Rhule, P. (2000, April, 16). A special report on teens & safety: *USA weekend's 13th annual teen survey finds our kids are afraid.* Available Online: www.usaweekend.com/00_issues/000416/000416teen.html

Rose, L. C., & Gallup, A. M. (2000). *The 32nd annual Phi Delta Kappa/Gallup poll of the public's attitudes toward the public schools.* Available Online: www.pdkintl.org/kappan/kpol0009.htm

Rumberger, R. (1987). High school dropouts: A review of issues and development. *Review of Educational Research, 57,* 101-121.

Rumberger, R., Ghatak, R., Poulos, G., Ritter, L., & Dornbusch, S. (1990). Family influences on dropout behavior in one California high school. *Sociology of Education, 63,* 283-299.

T.L.O. v. New Jersey. (1985). *New Jersey State law library.* Available Online: www.njstatelib.org/aboutus/SGIS/liblaw.htm

Udry, J. (2000). *The national longitudinal study of adolescent health: Research report.* Chapel Hill, NC: University of North Carolina. Available Online: www.cpc.unc.edu/projects/addhealth

Endnote

[1] Portions of this chapter are adapted and/or reprinted with permission. The original reference for portions of this chapter is as follows: Stephens, R. (1998). Safe school planning. In D. S. Elliott, B. A. Hamburg, & K. R. Williams (Eds.), *Violence in American schools: A new perspective* (pp. 253-289). New York: Cambridge University Press.

4

危機

Creating Nurturing Classroom Environments: Fostering Hope and Resilience as an Antidote to Violence

Robert B. Brooks, Ph.D.
Harvard Medical School and McLean Hospital

One effective way in which I can describe the ingredients of creating a nurturing classroom environment is to share a journey, a mindset, and a selection of strategies. The journey is the path I have taken as a clinical psychologist, therapist, principal of a school in a locked door unit of a psychiatric hospital, and consultant to many schools. The mindset represents the transformation that occurred in (a) the way I viewed angry, resistant youths, (b) my own feelings of efficacy, and (c) my understanding of the main components of classroom environments that would lessen hostility and increase cooperation. The strategies or interventions we use to create school environments that are safe and nurturing and support the process of learning are rooted in the mindset or the assumptions we have about ourselves and the youths with whom we work.

A model of crisis prevention rather than crisis intervention guides this mindset. That is, the main focus is not on what to do when a crisis emerges, but rather on what we can do to create environments in our schools that will minimize these crises from emerging in the first place. I am not downplaying the importance of having clear crisis plans in place, but in this chapter my goal is to outline an approach to school safety and school violence that places the spotlight on prevention.

I have often been asked what prompted my interest in creating positive classroom environments and in fostering motivation, self-esteem, hope, and resilience in angry and resistant youths. To be honest, my interest can be traced to how ineffectively I interacted with these youngsters when I first began as a therapist in the mid-1960s (Brooks, 1997; Brooks & Gunther, 1997) and when I became the principal of a school in a locked door unit in a psychiatric hospital in the early 1970s. In many ways, the mid-1960s represented the dark ages of our understanding of such youngsters. It was a time when we possessed little, if any, knowledge about the biological substrates of emotions and behaviors; we were unaware of the extent to which the inborn temperament of children interacted with the environment in an ongoing, dynamic fashion to contribute to the formation of their personality, to their capacity to delay gratification, to handle frustration, to soothe themselves, to respond to others, and to learn. Similarly, we knew little about learning disabilities, attention-deficit/hyperactivity disorder, learning styles, or multiple intelligence theory. Thus, we could not appreciate how these factors could have such a powerful impact on how successfully a child met developmental challenges.

The Blame Game Phase of My Journey

This limited knowledge, together with my own insecurities as a beginning therapist and school principal, contributed to an ineffective approach in working with these youngsters and their parents. If children and adolescents did not show signs of improvement under my care, I routinely anointed them with such labels as "oppositional," "unmotivated," or "resistant," thus blaming them for a lack of positive change and for failing to learn.

The blame was manifested in many forms, some subtle and some not so subtle. I assumed that all kinds of behavior were well within the control of the child and that changing behavior was a matter of "will." I would ask hyperactive children who were roaming my office to sit down (I'm not certain why I believed that therapy would be enhanced if a child were seated, especially since I often did my best thinking standing up and moving around), and when they did not respond to my request, I thought of them as oppositional. I constantly exhorted my patients to "try harder," and when they appeared not to follow my advice, I questioned their motivation and their desire to change. The blame extended to the parents of these youngsters. When interventions did not work I frequently questioned the motivation, skill, or perseverance of the parents. If children were angry or oppositional I was quick to assume that these feelings were a consequence of poor parenting, never appreciating the major contribution of a child's inborn temperament to how they felt and perceived their world (Brooks, 1998; Greene, 1998; Ingersoll & Goldstein, 1995).

Perhaps the defining moment of my career occurred when I became principal of a school in a locked door unit of a psychiatric hospital. Within several months of accepting this position I began to experience headaches and stomachaches before going to work each morning that were prompted in large measure by my sense of confusion and helplessness about what to do with these very challenging youth. As a result, I began to dislike all of the children and adolescents in my school, a rather poor attitude for a school principal. My response to these angry, violent youths was to become increasingly punitive; this was reflected in the classroom environments I helped to create, environments devoid of any sense of nurturance and caring. Little did I realize that my approach was actually reinforcing rather than lessening resentment and anger among the students.

This blaming and punitive phase of my professional career left me feeling upset and dissatisfied. I actually began to assume that these students were "out to get me," that they were "placed on this earth to make my life miserable." My work was increasingly pervaded by feelings of frustration, helplessness, and burnout. I was relying on therapeutic and educational interventions that produced limited success, but I was unable to develop alternative strategies to help youngsters who displayed angry or defiant behaviors in the classroom. Staff meetings were dominated by discussions of how to restrain these youths rather than how to reach and teach them. As my feelings of burnout became more intense, however, I was forced to do a great deal of self-reflection from which emerged a far more positive, energizing mindset and approach.

I came to appreciate that one of the most powerful obstacles to helping these youths and designing a more nurturing, caring school environment was the mindset and negative assumptions my staff and I had developed. In essence, I was blaming the very people I was supposed to help. As a result, I wondered, "Are these students truly resistant? Were they put on this earth to make my life miserable? Do they really not want to get better? Are they lazy and unmotivated, as some have accused them of being? Or is my approach and the approach of my teachers not providing them with what they need?"

Empathy: The Road to Understanding

My intent in asking these questions was not to shift blame from my students to myself, but rather to challenge myself to expand my understanding of what my patients were experiencing. I realized that if I were to become a more effective and helpful therapist and school principal, I had to begin to change my negative mindset. A first step was to refine my ability to be empathic, to see the world through the eyes of the youngsters with whom I was working (Brooks, 1991). How could I be of help to others if I did not understand their experiences? Although empathy is a vital interpersonal skill in any relationship, it is often difficult to achieve. I have discovered that many people judge themselves to be empathic, but are they? How often do we question how others (our children, patients, students, colleagues) would describe us, which is a significant component of empathy? In addition, I have found that it is more difficult to be empathic when one is disappointed, upset, angry, or frustrated with the other person, including the students with whom we work.

Given my developing belief in the importance of empathy, I placed the spotlight on this concept in all facets of my clinical work. As an example, at some point during my initial meeting with parents who have sought a consultation about one of their children, I pose several questions to assess and then promote empathy. These questions include, "Describe a typical day in your child's life, but through your child's eyes. How does your child feel when he/she first gets up in the morning, sees you, and goes to school? How would your child describe you? How does your child feel about himself/herself, about his/her abilities to succeed? How does your child experience being taught, praised, disciplined?" Interestingly, many parents have told me that of all the questions I raised, the ones pertaining to empathy not only were some of the most difficult to answer, but also were the most important since they triggered much thought.

Similarly, when consulting with educators, I ask them how their students would describe them and the work they are doing together. I ask how students would describe their school experiences. I emphasize that every time we interact with youngsters they form images of us, and these images will play a large role in their ability to relate to and learn from us.

Empathy is the road to understanding in any relationship and is a key to a positive mindset that will lead to effective interventions. Goleman (1995) has highlighted empathy as a major component of "emotional intelligence." How can we raise, educate, or do therapy with children and adolescents without comprehending their experiences? How can we create nurturing classroom environments that lessen violence without appreciating the world of our students? Empathic educators continually ask two main questions when relating to students: (a) In anything I say to or do with students, what do I hope to accomplish? and (b) When I say or do something, am I saying or doing it in a way in which children will be most responsive to hearing me?

Although answering the first question is essential, since it relates to goals and expectations, reflecting upon the second question is equally important. Many educators may have clear notions of what they hope to accomplish, but they attempt to do so in ways that are prone to failure. For example, a teacher may have as a goal motivating a student with learning disabilities to produce more work. One of the teacher's prime ways to do so is to exhort the student to try harder. Although the teacher may be well intentioned, the recipient of such a comment typically experiences it in a negative, accusatory, judgmental way. When students feel accused or judged they are less likely to be cooperative. Consequently, the teacher's approach will not lead to the desired results. The more we develop empathy, the more we recognize the possible negative impact of saying such things as "try harder" and the greater the likelihood that we will search for more productive alternatives for motivating students and fostering positive school climates.

As an example of an alternative approach, I frequently say to youngsters who are angry and struggling with school that the problem is not that they are not trying, but rather that the strategies they are using to learn or to handle their feelings or the strategies the teachers are using to teach them are not working. I have found that children and adolescents are much more willing to discuss their struggles when I attribute these problems to strategies that can be changed rather than to a more moralistic view of "not trying."

What Empathy Taught Me: The Centrality of "Earned" Self-Esteem

In my attempt to become more empathic and to gain a greater appreciation of these youngsters' struggles, I gathered information from them through stories I encouraged them to write about their lives (Brooks, 1987). As I read the words of these angry or resistant students, it became evident that self-esteem and a loss of hope played a central role in their lives. Not only did their stories reflect feelings of inadequacy, but also as they thought about their future, they entertained little hope that things would improve. When youngsters feel hopeless they are likely to engage in destructive behavior (Beck, 1986).

For example, Matt came to see me as a young adolescent who was diagnosed with learning and attentional problems. He was depressed and held a bleak view of his future. His description of school, which follows, captures the way in which many youngsters with special needs experience school; it serves as a testimony to the importance of being empathic and gaining a clearer understanding of the despair and sense of hopelessness that haunt these youngsters:

> School has been and still is something I dread profusely. Going to school has been like climbing up a tremendous, rocky mountain with steep cliffs and jagged, slippery rocks. This mountain is very grey and always covered in dark, murky, cold clouds. I step forth to take on this task of climbing this huge mountain. Each step is a battle against strong, howling, icy winds. The winds contain frigid rain that slams against my body, trying to push me down. I keep battling my way up. Sometimes I am knocked down, and sometimes I have to stop to regain my strength. My body is numb. My hands shake like leaves in the wind as I claw myself up the mountainside. Not being able to open my eyes, I blindly claw myself up the steep cliff. I stop because I am in such great pain. I look up and see that my struggle has hardly begun. Sometimes I just do not want to go on any further.

As I read stories written by Matt and other youngsters, I came to appreciate the burden most of these youngsters face, a burden replete with feelings of inadequacy, helplessness, hopelessness, and anger. I recognized that many of the behaviors I had observed in my patients—behaviors that are frequently labeled as resistant or oppositional—represented desperate attempts to cope with their emotional pain (Brooks, 1992, 1997; Goldstein & Mather, 1998; Wexler, 1991). Unfortunately, many of these coping strategies such as quitting, cheating, bullying, clowning, avoiding, being aggressive, and rationalizing were ultimately self-defeating and counterproductive, adding to rather than relieving distress.

Although children may be angry for a variety of reasons, in my experience one source of anger for many of these youngsters is low self-esteem with accompanying feelings of frustration, hopelessness, and helplessness. Low self-esteem is also evident in depressed youths. Low self-esteem often pervades many areas of a youngster's life. If you feel inadequate in school, if dreams of success fade into the background, motivation is likely to suffer, and then these children will be accused of "not trying." In addition, many of these youths possess poor interpersonal skills that contribute to less than satisfying peer relationships, adding to an overall picture of sadness. As a psychologist and principal of a school, I wondered if school environments could be designed that would nurture hope and self-esteem.

Self-Esteem: A Definition

While numerous clinicians and educators have emphasized the positive qualities of high self-esteem, others have viewed the concept of self-esteem from a much different perspective, contending that many individuals who advocate building self-esteem are doing so at the expense of teaching responsibility, self-discipline, and caring (Baumeister, 1996; Lerner, 1996). One factor contributing to these two different perspectives may reside in the confusion between what Lerner (1996) calls "feel-good-now" self-esteem versus "earned" self-esteem. She argues that:

> Earned self-esteem is based on success in meeting the tests of reality—measuring up to standards—at home and in school. It is necessarily hard-won and develops slowly, but it is stable and long-lasting, and provides a secure foundation for further growth and development. (p. 12)

In contrast, feel-good-now self-esteem is perceived as an approach to reinforcing self-esteem that does not challenge children, nor set up realistic expectations and goals, nor prepare them to cope with mistakes and failures. Lerner (1996) believes that in the quest to help children feel good now, authenticity and dedication are sacrificed, replaced by false praise and lowered standards.

Self-esteem as used in this chapter parallels the notion of earned self-esteem and is in concert with the definition advanced by the California Task Force to Promote Self-Esteem and Personal and Social Responsibility (Mecca, 1990). The California group defined self-esteem not only in terms of "appreciating my own worth and importance" (p. 1), but also "having the character to be accountable for myself and to act responsibly toward others" (p. 1). This definition proposes that a basic ingredient of self-esteem includes the respect and compassion that we demonstrate toward others and is very different from narcissism or conceit.

Self-esteem may be understood as embracing the feelings and thoughts that individuals possess about their competence and about their abilities to have a positive impact, to confront rather than flee from challenges, to learn from both success and failure, and to treat themselves and others with dignity. Self-esteem directs and motivates our behavior and, in turn, the outcome of these behaviors affects our self-esteem so that a dynamic, reciprocal process is continuously in force, playing a significant role in determining whether or not a child will become resilient (Brooks, 1992, 1994).

Two Frameworks to Understand the Components of Self-Esteem and Motivation

If our interventions to create positive school climates and to lessen anger and defiance in youths are to be guided, in part, by the concept of earned self-esteem, it is important to examine the mindset of individuals with high self-esteem. To appreciate the components of this mindset will help parents and professionals reinforce self-esteem, hope, and cooperation in children and adolescents.

Attribution Theory

One promising framework originally proposed by psychologist Bernard Weiner (Weiner, 1974) is called attribution theory. I found this theory appealing because the research examining its fundamental assumptions included children with special needs. In addition, its basic tenets could be applied to the real world. I could actually use attribution theory as a blueprint for what I said and did with at-risk children and with their parents and teachers to foster self-esteem and hope.

Children encounter numerous challenges as they grow, some of which result in success, others in failure. Attribution theory highlights that youngsters assume different reasons for why they succeed or fail and that these reasons, which vary from one child to the next, are strongly tied to their self-esteem. In terms of success experiences, research indicates that children with high self-esteem believe that their successes are determined in large part by their own efforts, resources, and abilities. These youngsters assume realistic credit for their accomplishments and feel a genuine sense of control over their lives. They are typically children who experience success early in their life within a responsive and encouraging environment. They are likely to be very motivated to face new challenges.

In contrast, youths who have encountered many frustrations and disappointments and whose self-esteem has suffered erosion are more likely to assume that their achievements are predicated on luck, chance, fate, or variables outside of their control, thus weakening their confidence in being able to succeed in the future. For instance, I have worked with many children with learning problems who quickly dismiss a high grade with such comments as, "I was lucky" or "The teacher made the test easy." These children minimize the role they have played in achieving any success; unfortunately, the cumulative effect of perceived failure outweighs any success experiences.

Self-esteem and motivation are also strongly implicated in how children comprehend their mistakes and failure. As an example, two children in the same third-grade class have failed a spelling test. One child thinks, "I can do better than this. Maybe I have to study more or ask the teacher for extra help." The second child explains the low grade by saying, "The teacher stinks. He never told us these words would be on the test. It's his fault I failed." Or, to take another example, a child who felt he was incapable of learning constantly hit other students. As he gained insight into his difficulties, he told me in therapy, "I'd rather hit another kid and be sent to the principal's office than have to be in the classroom where I felt like a dummy."

The child who is willing to seek additional help and/or work more diligently basically believes that mistakes are experiences to learn from rather than feel defeated by. Such children typically attribute making mistakes to factors that are within their power to modify, such as a lack of effort (especially if the task is realistically achievable) or ineffective strategies (e.g., poor study habits). In marked contrast, students who resort to blaming or hitting others typically adhere to the painful view that "I am a failure, I cannot change, I cannot do well." Rather than believing that mistakes are the foundation for future learning, children with low self-esteem frequently experience each new mistake as another rock being placed around their necks, weighing them down more and more. To such youngsters, mistakes result from conditions that cannot be easily modified, such as lack of ability or low intelligence; given this belief, their motivation suffers and their anger often increases.

A vicious cycle is set in motion when children believe they cannot learn from mistakes. Feeling hopeless and wishing to avoid further perceived humiliation, they are apt to quit, offer excuses, cast blame on others, or resort to other ineffective ways of coping, such as assuming the role of class clown or class bully. As these youngsters reach teenage years, our attempts to teach and encourage them may be met with angry retorts such as "Leave me alone!" "I don't care!" "It's my life, I'll do what I want with it" and/or acting out behaviors. In my experience these children care much more than they acknowledge, but they feel hopeless and believe they are unable to change their situation. They do not even want to entertain the notion that things may improve. For them, any hope is false hope that eventuates in further disappointment. Although the adults in their lives may believe that such youngsters are quitters or lack perseverance or are bullies, we often fail to comprehend that these behaviors are rooted in a sense of hopelessness and a desperate attempt to avoid further humiliation (Brooks, 1992; Wexler, 1991). Working with these at-risk youths involves helping to change their negative attributions and mindsets (Bernstein, 1996).

Attribution theory offers significant guideposts for designing classroom climates that will reinforce the self-confidence and motivation of angry and defiant students. The following questions stem from this theory:

1. How do we create a school environment that maximizes the probability that students will not only succeed but that they also will experience their achievements as predicated in large measure on their own abilities and efforts? Or, stated somewhat differently, how do we assist youngsters to assume an increasing sense of ownership and responsibility for what occurs in their lives?

2. How do we create a school environment that reinforces the belief that mistakes are frequently the foundation for learning, that mistakes are not only accepted, but also expected? How do we create an environment that lessens fears of being humiliated or embarrassed, fears that often trigger sadness and anger?

Deci's Approach

A second framework is based on the work of psychologist Edward Deci who has studied self-esteem and motivation through the lens of youngsters' needs (Deci & Chandler, 1986; Deci & Flaste, 1995; Deci, Hodges, Pierson, & Tomassone, 1992). His model has many similarities to Glasser's (1997) choice theory (formerly called control theory) and the work of Brendtro, Brokenleg, and Van Bockern (1990). It suggests that youngsters will develop high self-esteem and be more motivated to engage and persevere at school tasks when the adults in their lives have created a school environment that satisfies basic needs. Deci highlights three needs that provide direction for fostering self-esteem and motivation.

1. ***To belong and feel connected.*** Youngsters are more likely to thrive when they are in environments in which they feel they belong and are comfortable, in which they feel appreciated. Many adolescents join gangs to satisfy this need for connectedness and identity. When youngsters feel alienated or detached they are more likely to act out and fail at school (Strahan, 1989). Related to this feeling of belonging is the importance of helping each child to feel welcome in the school environment. When I asked students of all ages what a teacher could do each day to help them to feel welcome in school, the two most frequent responses I received were: (a) being greeted warmly by a teacher who uses your name, and (b) a teacher smiling at you. Obviously, small gestures can go a long way toward assisting at-risk children to feel welcome at school and in other environments. If students do not feel welcome, they are more prone to becoming angry.

2. ***To feel autonomous and have a sense of self-determination.*** At the core of most theories of self-esteem and motivation, including attribution theory, is the concept of ownership and self-determination (Brooks, 1991). Motivation is increased when people genuinely believe that their voice is being heard and respected, when they believe they have some control over what is occurring in their lives (Dicintio & Gee, 1999). If students perceive they are constantly being told what to do and that their lives are being dictated by adults, they are less likely to be enthused about engaging in learning tasks that they feel are being imposed upon them. If anything, their main motivation may be to avoid or oppose the desires of others. A power struggle or angry outbursts are likely to ensue. An emphasis on reinforcing self-determination requires that educators use classroom experiences to teach youngsters how to solve problems and make wise choices and decisions. In addition, we must provide these children with ongoing opportunities to develop and refine these skills.

3. ***To feel competent.*** We all hope to be successful, to possess skills in our lives that help us feel competent and accomplished, skills that generate satisfaction and pride. Unfortunately, many children do not feel competent. Feelings of incompetence, which are often associated with anger and sadness, prompt children to retreat from challenges and to engage in self-defeating behaviors, including aggression, that serve to intensify an already difficult problem.

It is important to emphasize that all students require positive feedback and encouragement from educators. A focus on encouragement, however, should never be confused with giving false praise or inflated grades since children are quite perceptive in knowing when they are receiving undeserved positive evaluations. As noted earlier, positive feedback must be rooted in actual accomplishment and success, which requires teachers to provide opportunities for children to succeed in areas judged important by themselves and others. The students' accomplishments should be displayed for others to see. (What good is listing a child's strengths on an educational plan, for example, if no one witnesses these strengths?)

In addition, a focus on competencies and positive feedback is not mutually exclusive with offering feedback to correct a child's performance or behavior. Corrective feedback, however, must be undertaken in a nonaccusatory, nonjudgmental manner that does not humiliate the child. Corrective feedback is most effective when presented to the student as a problem to be solved.

The Search for Islands of Competence

As we consider the tenets of attribution theory and Deci's model, it is important to recognize that any intervention that teachers implement to develop a classroom milieu in which self-esteem, motivation, hope, and resilience are fostered must be guided by a strength-based approach and must promote autonomy and self-determination in a climate of genuine caring for and appreciation of the child. Although we must never minimize a child's difficulties, weaknesses, and vulnerabilities, we must not lose sight of the strengths of angry, defiant children. If we are to minimize anger in our schools, we must ensure that all students feel welcome, important, and hopeful (Charney, 1991; Heath, 1999; Malicky, Shapiro, & Mazurek, 1999).

Some youngsters are much more confident playing baseball or basketball than they are taking a math test or talking with their peers. Other children and adolescents feel secure in the classroom but are very self-conscious and anxious playing a sport, and still others are self-assured working on the motor of a car or drawing a cartoon but dread writing an essay. A child's self-esteem may vary from one situation to the next. Thus, there is little wonder that some children are sad or angry in certain environments or with certain people, but more content and cooperative at other times. Unfortunately, if youngsters experience self-doubt and failure in many situations, especially those they judge to be of value to significant others, their overall sense of competence and confidence is lessened and they are more likely to demonstrate anger. I use a metaphor to capture this feeling that involves an image in which I see these youngsters swimming or drowning in an ocean of self-perceived inadequacy. In therapy and in the classroom, these children have communicated to me that they doubt they will ever be successful. To counteract this image of despair, I believe that every person possesses at least one small "island of competence," one area that is or has the potential to be a source of pride and accomplishment (Brooks, 1999b).

This metaphor of islands of competence is not intended to be merely a fanciful image, but rather a symbol of hope and respect, a reminder that all children and adolescents have unique strengths and courage. Caregivers have the responsibility to locate and reinforce these islands of competence. If we can find and reinforce these areas of strength, we can create a powerful ripple effect in which children may be more willing to venture forth and confront situations that have been problematic. For this reason whenever I meet with parents or teachers or other professionals to discuss an angry youngster, within a few minutes I ask them to describe the child's islands of competence. Then I ask how we might strengthen these islands and display them for others to see.

Clinicians and researchers have emphasized the importance of reinforcing these areas of strength. Rutter (1985) in commenting about resilient individuals noted, "... experience of success in one arena of life led to enhanced self-esteem and a feeling of self-efficacy, enabling them to cope more successfully with the subsequent life challenges and adaptations" (p. 604). Similarly, psychologist Mark Katz (1994) has written, "... being able to showcase our talents, and to have them valued by important people in our lives, helps us to define our identities around that which we do best" (p. 10).

The case of a young boy who was referred to me illustrates the importance of identifying a child's islands of competence. Billy was an angry and depressed 10-year-old boy with learning problems who dealt with his anxieties about school by hiding behind the bushes of the school instead of entering the building. In our first session, Billy and I discussed why he hid behind the bushes. He responded quickly and directly, informing me that he "liked the bushes better than he liked school." Rather than engage in a debate about the merits of bushes versus schools, I decided to discover what he saw as his islands of competence. He responded that he enjoyed taking care of his pet dog. With his permission, I mentioned Billy's expertise in taking care of animals to the school principal, suggesting that the school might benefit from the presence of a "pet monitor."

The following day the principal scheduled a meeting with Billy and asked if he might be interested in becoming the school's first pet monitor, even handing Billy a pet monitor "union card" that he had created to emphasize the position's importance. When Billy asked about a pet monitor's responsibilities, the principal said that to begin with, Billy would be expected to come to school 10 minutes early each day to take care of a rabbit the school had recently purchased.

Billy accepted the offer and handled his duties in a very responsible manner, in marked contrast to his history with academic requirements. Within a short time, he began to take care of other pets. Billy's teacher communicated how impressed she was with his knowledge of pets and helped him to write a manual about animal care. Billy had always been reluctant to write, but under these circumstances his hesitancy disappeared since he felt more confident and recognized that he had information to communicate. His manual was placed in the school library. In addition, by the end of the school year, Billy "lectured" in every classroom in the building about taking care of pets.

Billy's aggressive outbursts and his avoidance of the school building decreased significantly once he assumed the position of pet monitor. Very importantly, Billy's teacher and principal had been willing to take a risk and change the way in which they had been approaching his avoidant behavior. Rather than seeing Billy as a resistant, annoying child who had to change his behavior, they had the courage to ask what they could do differently so that he would not be as frightened in school.

Resilience and Hope

All parents worry to some extent about what the future holds for their children; this worry is greatly magnified for parents of children who are angry, defiant, and/or depressed, especially when they witness their children confronting so many burdens and frustrations. When speaking with these parents, I often hear this question: "Will my child always be so unhappy and angry and feel so unsuccessful?" Educators often pose a similar question when they question whether they can "reach" students who have replaced hope with anger.

Faced on a daily basis with children who have low self-esteem, it can become very easy for caregivers to focus on pathology and risk factors rather than on those factors that help children bounce back. Yet, as I encountered a number of adults who as children experienced years of frustration, failure, humiliation, or abuse, and were now leading satisfying, successful lives, my focus and questions shifted. I began to ask, "Why are some high-risk children successful as adults while others are not?"

Answering this question is perhaps one of the most important tasks for those of us who work with, raise, or educate youngsters. If we can understand those factors that contribute to children bouncing back, to becoming hopeful and resilient, then we can develop and implement more effective interventions that will give all of our children a fighting chance.

Fortunately, during the past 15 to 20 years there has been a burgeoning literature focusing on the topic of resilience (Beardslee, 1989; Brooks, 1994, 1997, 1999b; Brooks & Goldstein, 2001; Katz, 1994, 1997; Rutter, 1985, 1987; Werner, 1993; Werner & Smith, 1992). Researchers and clinicians have noted that three interrelated domains influence the occurrence of resilience, namely, the inner characteristics of the child, the family, and the larger social environment (Hechtman, 1991). Inner resources of the child that contribute to resilience include an "easy" temperament from birth, more advanced problem-solving skills, good social skills, and effective coping strategies. Very importantly, resilient youngsters possess a high level of self-esteem, a realistic sense of personal control, and a feeling of hope. Concerning the family dynamics, it is not surprising to find that resilient children are more likely to grow up in homes characterized by warmth, affection, emotional support, and clearcut and reasonable guidelines, limits, and consequences.

Supportive adults outside the immediate family have also proved to be a major source of resilience. When resilient adults were asked what important factors in their childhood helped them become resilient, they invariably responded: "an adult who believed in me." Segal (1988) referred to such a person as a "charismatic adult," someone from whom a child or adolescent gathers strength. Schools have especially been highlighted as environments that can provide angry, resistant, or alienated youngsters with experiences that enhance their self-esteem and competence, lessen their sadness and bitterness, and strengthen their resilience and hope (Brooks, 1991; Curwin, 1992; Goldstein, 1995; Segal, 1988). In this regard, a recent report issued by the U.S. Department of Education (Dwyer, Osher, & Warger, 1998) about safe schools noted:

> Research shows that a positive relationship with an adult who is available to provide support when needed is one of the most critical factors in preventing student violence. Students often look to adults in the school community for guidance, support, and direction. Some children need help overcoming feelings of isolation and support in developing connections to others. Effective schools make sure that opportunities exist for adults to spend quality, personal time with children. (pp. 3-4)

Strategies to Foster Self-Esteem, Motivation, Hope, and Resilience

A number of self-esteem strategies, predicated on attribution theory and Deci's framework, build upon a child's islands of competence to reinforce a sense of confidence, motivation, hope, and resilience. These strategies can be applied in our homes, schools, and offices. As many will recognize, these strategies also can help to develop skills implicated in emotional intelligence (e.g., self-awareness, empathy, self-control, responsibility, and ease in interpersonal relationships), skills crucial for success and contentment in life (Goleman, 1995). The following are a selected group of these strategies together with some recommendations for the implementation of an orientation period at the beginning of the school year:

1. Developing Realistic Expectations and Goals and Making Accommodations When Necessary

I am often asked about realistic expectations and goals in our schools and homes for children of different ages. My answer is, "I don't know. First, tell me about your child and then we can decide on realistic expectations and goals." Although a wealth of research proves that children have different temperaments from birth (Chess & Thomas, 1987), possess different learning styles (Levine, 1994; Rief & Heimburge, 1996), and that multiple intelligences are distributed differently among children (Gardner, 1983), we often give lip service to accepting children for who they are. Instead, we respond to youngsters as if they were a homogeneous group. When we fail to make appropriate accommodations based on the unique quality of each child, children are more likely to fail and become sad and angry and display aggressive outbursts. This scenario is often seen in the school environment.

For example, it is not unusual to hear a teacher say it would not be "fair" to offer accommodations for one child because of what the other children might feel. I appreciate what the teacher is saying, but I also believe that if children are different, the least fair thing we can do is to treat all of them the same. If we do not teach students in the ways they are able to learn best, we will continue to have many youngsters who feel mistreated, ill-at-ease, alienated, and angry in our schools. The issue of fairness must be addressed, however, lest other students begin to resent those students who are receiving accommodations. One suggestion I advocate for schools is to use the first couple of days of the new school year as an orientation period (Brooks, 1997, 1999a). During this period, teachers do not take out any books, but instead use the time to set the foundation for a classroom climate in which all students have the opportunity to thrive. Key questions and concerns are considered and possible obstacles to learning are confronted before they became obstacles.

As an illustration, to minimize the possibility that children think a teacher is unfair because some children are doing more reading or homework than others, on the first day of school, the teacher can discuss with the class how each of them is different, how some students can read more quickly, how some can solve math problems more efficiently, and how some can run a mile in less time. The teacher can explain that in light of these differences, there will be different expectations of the amount and kind of work done by each student. Next, the teacher can say, "Since I will treat each of you somewhat differently because you are different, one of my concerns is, if you begin to feel I am not being fair, it will interfere with your learning. Thus, if at any time during the year you feel I am not being fair, I want you to tell me so we can discuss it." I have received feedback indicating that when teachers bring up the issue of fairness before it has become an issue, it remains a nonissue and permits teachers to accommodate each student's needs without prompting negative feelings on the part of others. It lessens the frustration, anger, and sadness that are typically byproducts of frustration. I also suggest that teachers communicate the same message about fairness to parents, perhaps through a short, written statement of class philosophy that is sent home.

The kinds of accommodations I typically recommend do not require major modifications in a student's program, nor do they demand that a teacher have extremely different educational plans for each student in the classroom. I believe that effective accommodations on the part of parents, teachers, and other professionals need not be complicated. It requires is that all parties—students, teachers, therapists, parents—appreciate a child's strengths and weaknesses, share an understanding of appropriate expectations and goals, and define what each has to do to maximize the probability of success in meeting these goals. We must help at-risk youths to understand their strengths and vulnerabilities and the accommodations that will help them to succeed. Realistic expectations lessen the frustration that results in anger and/or sadness. A few examples of typical accommodations follow:

Homework time. Some youngsters experience attending school as the equivalent of climbing Mt. Everest each day. Then they are required to do homework after school. If they have learning problems, they often must spend two or three times longer than their peers to do homework. By bedtime they are frustrated and exhausted, as are their parents. Common sense would dictate that a time limit be established for homework, regardless of how much work is actually finished. For example, if most students can complete a homework assignment in an hour, then the limit should be approximately an hour for all students—even those with special needs. Some might argue that this approach will result in some children not completing as many problems as other students in the class and, thus, not learning as much; however, asking these children to spend several more hours per evening on homework will typically prove counterproductive. It may produce sadness, anger, and defiance.

Testing. Students with learning or attentional problems usually encounter more difficulty taking timed tests than their peers. As one child with learning difficulties once asked me with tears in his eyes, "Why did they ever invent timed tests?" I have seen the test scores of students increase noticeably when taking untimed tests and, yet, they only required another 10 minutes. The pressure of a timed test no longer existed and they were more relaxed. Similarly, some students will display far more knowledge when answering questions orally than when having to write these same answers. We should test students under the best possible conditions for them. Such accommodations should not be viewed as spoiling these youngsters, but rather as treating them with fairness and dignity.

Assignment assistants. I have worked with many youths who engage in ongoing battles with parents about homework. The nightly routine is filled with frustration and anger, and family harmony is almost nonexistent. The reasons why students do not do homework vary. Some students find it difficult to copy homework assignments from the blackboard. Providing the child with a monthly syllabus of assignments can be helpful. (It is interesting to note that college professors typically distribute a syllabus for the entire semester during the first class—I'm not certain why we cannot do the same in our elementary, middle, and high schools.) It may also be helpful to assign a buddy to ensure that the child has an accurate picture of what homework is required.

School books at home. A vast number of books are lost being transported between home and school. Providing two sets of books to a student, one for home, the other for school, so that no textbooks have to go back and forth, helps many students. It is one less pressure that students have to worry about, giving them more time to focus on learning the material in the books and less time to be angry or depressed.

2. Developing Responsibility by Providing Opportunities to Contribute to Others

In my experience when children develop a sense of accomplishment and pride, they are less likely to feel sad or angry and less likely to engage in defiant, uncooperative behaviors. It is therefore essential to provide youths with opportunities for assuming responsibilities, especially those that help them to feel they are making a contribution to their home, school, or community environments. The experience of making a positive difference in the lives of others reinforces self-respect and a sense of hope. It serves as a powerful antidote to feelings of defeat, anger, and despair (Brooks, 1988). One of the best ways to boost self-esteem and motivation is for youngsters to taste success. As Werner (1993) has noted:

> Self-esteem and self-efficacy also grew when youngsters took on a responsible position commensurate with their ability, whether it was part-time paid work, managing the household when a parent was incapacitated, or, most often, caring for younger siblings. At some point in their young lives, usually in middle childhood and adolescence, the youngsters who grew into resilient adults were required to carry out some socially desirable task to prevent others in their family, neighborhood, or community from experiencing distress or discomfort. (p. 511)

The child who was asked to become the pet monitor of the school is an example of a youngster making a contribution. Other examples include the following:

Charitable projects. An educator I know enlisted visually handicapped adolescents with learning difficulties to create piggy banks to sell and sponsored a bake sale and raffle, with the proceeds going to a needy family. The educator noted that the students' self-esteem and cooperation improved as did the many academic skills that were involved in the charitable project.

"Budding." I visited an elementary school in which fifth-graders were "buddies" with kindergarten and first-grade students. They would spend time each week with their buddies in a variety of possible activities, including reading to them, helping them with work, or playing a sport. All of the students benefited from this approach, and the atmosphere of cooperation that permeated the building impressed me.

Committee membership. A school social worker formed a committee of five elementary school students who were often absent from school. The committee focused on the question of what prompted students to be absent, and the five students engaged in research to answer the question. Not only did they prepare a report of their findings, but they also recommended keeping track of the attendance of first-graders and intervening early for all first-graders who were absent a great deal. After becoming members of this committee the attendance records of the five students improved significantly. They now had a reason to come to school.

School beautification. Youngsters can take care of plants in school, paint murals on the wall, or hang up favorite drawings. When I was a principal I found that asking students to decorate the walls was a strong antidote to vandalism.

Peer tutoring. Cooperative learning as well as tutoring younger children is a powerful way of increasing a sense of belonging and competence in the school setting (Brooks, 1991). I am reminded of the impressive results of the Valued Youth Partnership Program reported by the Carnegie Council on Adolescent Development

(Hornbeck, 1989). The program was developed to address the large percentage of youths dropping out of school before they reached high school. It was highly successful, as the Carnegie report noted:

> A rise in tutors' self-esteem is the most noticeable effect of the program ... As a result, only 2 percent of all tutors have dropped out of school. This is remarkable, given that all of these students had been held back twice or more and were reading at least two grade levels below their current grade placement. Disciplinary problems have become less severe, grades have improved, and attendance of tutors has soared. (p. 47)

3. Providing Opportunities for Making Choices and Decisions and Solving Problems: Reinforcing a Sense of Ownership

Theories of self-esteem and motivation as well as research about hope and resilience emphasize the importance of reinforcing the belief that one has some control over one's life. I believe that a sense of powerlessness is often one trigger for anger and defiance. To develop this sense of control, ownership, and autonomy, children require opportunities to learn the skills necessary to make sound choices and decisions and to solve problems. They also need opportunities, in keeping with their developmental level and interests, to apply and develop these skills, especially in those situations that have an impact on their lives (Adelman & Taylor, 1983; Deci & Chandler, 1986; Deci & Flaste, 1995; Deci, Hodges, Pierson, & Tomassone, 1992; Dicintio & Gee, 1999; Glasser, 1997; Kohn, 1993; Shure, 1994). If children and adolescents feel they are always being told what to do, if they feel they have little control over their lives, they are less likely to be cooperative. Teachers and other professionals have many opportunities to reinforce problem-solving and decision-making skills. The following are some examples:

Choice. I spoke with a group of teachers who always gave their students a choice in what homework problems to do. For example, if there were eight math problems on a page, the students were told they had to do six of the eight and it was their choice which six to do. The teachers told me that they actually received more homework on a regular basis when permitting their students some choice since it reinforced a sense of ownership for doing the homework. Similarly, a resource room teacher found that students were more likely to write when he offered them several different colored pens and asked them which color they would most like to use that day. When students are provided these kinds of options, they are less likely to view school as a hostile environment.

Guided problem solving. I advocate that teachers should incorporate some time in a class schedule to obtain the input of students about solving particular problems. I have found that assisting students to articulate what the problem is, to think of possible solutions to the problems, and to consider the likely consequences of each solution, increases the probability of children not only learning to solve problems, but also following through on the solutions (especially since they have helped to formulate the solutions).

For instance, when I was principal of the school we established a Student Council. The opportunity and structure for the student patients to discuss their concerns and criticisms noticeably lessened hostility and created a more responsible attitude.

Input. I believe that we must involve students from an early age in providing input about their own education. An article in *Teacher Magazine* (Jacobson, 1999) titled, "Three's Company," about parent-teacher conferences reported:

> When Michelle Baker first learned that her son Colin would take part in a parent-teacher conference, she was skeptical. "I thought, This is going to be a fiasco," she recalls. Instead, the meeting turned out to be a big success: Colin … showed unusual insight into his academic strengths and weaknesses. "He had the opportunity to hear his teacher talk about him with him sitting there," Baker says. "He was able to communicate and understand better what he was being judged on." (p. 23)

It is interesting to note that Colin was only in the first grade.

4. Establishing Self-Discipline by Learning to Discipline Effectively

As might be expected, many of the questions I am asked at my workshops, especially about angry and defiant youths, revolve around the issue of discipline. In turn, I often ask the audience to think about the purpose of discipline. Not surprisingly, the first response I typically receive focuses on the importance of establishing rules and guidelines to ensure that our home and school environments are safe and that both children and caregivers feel secure. I am in total agreement with this purpose of discipline, especially since I have seen what can occur in an environment in which rules, limits, and consequences are vague and inconsistently followed. But we must not lose sight of a second, very important purpose of discipline, namely, to promote self-discipline and self-control in our children. It is difficult to conceive of children developing high self-esteem, motivation, and resilience if they do not possess a comfortable sense of self-discipline, that is, a realistic ability to reflect upon one's behavior and its impact on others, and then to change the behavior if necessary. In essence, self-discipline implies ownership of one's own discipline.

Before examining more closely some strategies that nurture self-discipline without a loss of self-esteem, one point about discipline deserves special mention. As much as possible, parents, teachers, and other professionals should anticipate those situations that may prove very difficult for particular youngsters, those situations that are likely to result in disruptive behaviors. We should consider ways to help children either avoid these situations, until we know they are better able to manage them, or to provide them with alternative behaviors. One illustration of a preventative approach was the child who was appointed the pet monitor. Another example is asking a hyperactive child to take messages to the office every half hour to provide needed physical activity. One teacher told me that she asked a disruptive child, who was constantly being sent to the assistant principal's office for disciplinary purposes, to become the "assistant to the assistant principal." This position required the child to work in the assistant principal's office for a short time at the beginning of each day. The disruptive behavior ceased, especially as the child formed a more positive relationship with the assistant principal. In addition, the child's self-esteem increased.

Even if we create school environments that lessen the probability of students misbehaving, we still know that children will, at times, act in ways that invite disapproval from educators. Many angry and defiant youngsters require more limits and guidelines than their peers, but they are the first to experience limits as significant impositions on their life, arguing that the teachers are not being fair. We must remember that discipline stems from the word disciple and should be understood as part of a teaching process. In helping children to develop self-discipline, it is essential not to humiliate or intimidate them (Charney, 1991; Curwin & Mendler, 1988; Mendler, 1992). Humiliation and intimidation are more likely to result in increased anger and uncooperativeness, the very feelings and behaviors we wish to change. If we want children to assume responsibility for their actions and to perceive rules as being fair, they must understand the purpose of the rules and participate within reason in the process of creating these rules and the consequences that follow should the rules be broken. Adults often walk a tightrope when discipline is involved, maintaining a delicate balance between rigidity and flexibility, striving to blend warmth, nurturance, acceptance, and humor with realistic expectations, clearcut guidelines, and logical and natural consequences. Several examples follow:

Self-reflection. I spoke with an assistant principal of a middle school who asked students to write a brief essay while serving detention. They were given a choice of more than 30 topics, including what they would do if they ran the school, what they could do in the future to avoid detention, what dreams they had for their future. As I reviewed some of the themes the students had written about, I was impressed with their ability to reflect upon their lives and their behaviors and to consider alternative ways of behaving in the future. In addition, the exercise led to a decrease in defiant behaviors.

Shared rule making. During the orientation period I advocate for the first couple of days of school, I have encouraged teachers to ask students what rules were necessary in the classroom or school, the best ways to remember these rules (so that adults did not have to remind or nag them), and the most effective consequences should rules be broken. In recommending this approach, I also emphasize that students should be informed about nonnegotiable rules related to safety and security issues. Some teachers have voiced reservations about allowing students to have input in the creation of rules and consequences (they predicted that students would take advantage of the opportunity and do away with all rules), but I and others have found that the students make up strict rules and consequences. If anything, many teachers have reported they must help students to develop less rigid and harsh rules and consequences. The key point is that students are more likely to remember and follow rules they have helped to create since they feel a greater sense of ownership for these rules (Rademacher, Callahan, & Pederson-Seelye, 1998). In addition, if students have a difficult time following their own rules, teachers can use their difficulty as an opportunity to discuss more effective ways of remembering these rules.

I want to make one other important point about discipline. We must never forget that perhaps the most powerful forms of discipline involve positive feedback and encouragement. I include a discussion of this in point #6 when I consider ways to help our children feel special and appreciated.

5. Helping Children to Deal More Effectively With Mistakes and Failure

All children worry about making mistakes and feeling foolish. At-risk youngsters are typically more self-conscious and/or worried about making mistakes than their peers. As attribution theory highlights, these children believe that mistakes cannot be modified and are an ongoing source of embarrassment and humiliation. Many children spend more time and energy in attempting to avoid a task they believe will result in failure than in seeking solutions. This avoidance is often manifested in oppositional and defiant behaviors. Since self-esteem and resilience are linked to a child's response to mistakes and failure, we must convey the message that mistakes are part of the learning process. We can do so in a number of ways.

Modeling. Parents, teachers, and other professionals serve as models. I frequently ask youngsters to describe how their parents or teachers handle mistakes or frustrations. I have heard a wide array of responses including, "They scream," "They yell," "They don't talk with each other," "They walk around with a frown on their face." Obviously, these parents and teachers are not modeling effective ways of dealing with frustration.

Responding to mistakes. Teachers must reflect upon how they respond to a child's mistakes. This implies that we must have realistic expectations for children and not overreact to their mistakes or shortcomings. All of us from time to time become frustrated with the behavior of youngsters, but we must avoid disparaging remarks such as: "You have to pay closer attention." The goal is to communicate that mistakes will occur and we should learn from them. We can also engage a child in problem solving by asking what might help to minimize the mistake from occurring in the future.

Anticipating mistakes. Since the fear of failure has such a strong influence in classrooms, it should be addressed directly even before any student makes a mistake. This can be accomplished during the orientation period. One example is for a teacher to ask at the beginning of the new school year, "Who in this class feels that they are going to make a mistake or not understand something in class this year?" Before any of the students can respond, the teacher raises his or her own hand and then asks why they think this question was posed. The students' responses can serve as a catalyst to discuss how fears of making mistakes interfere with offering opinions, answering questions, and learning. The teacher can then involve the class in problem solving by asking what he or she can do as their teacher and what they can do as a class to minimize the fear of failing and looking foolish. To acknowledge openly the fear of failure renders it less potent and less destructive. Early in the school year youngsters can be taught that not understanding material is to be expected and that the teacher's job is to help them to learn. Mistakes can be "celebrated" as part of the educational process. This intervention for dealing with mistakes is important for all students, but even more so for those youngsters who feel vulnerable, sad, and angry.

Focus on the positive. Adults who focus on children's strengths and their capabilities rather than on what they cannot do lessen the fear of failure. For instance, the seemingly simple practice of teachers marking tests by adding points for correct answers rather than subtracting points for incorrect answers places the spotlight on the positive. I visited one school in which teachers engaged in this practice and did so with green rather than red ink, believing that the use of red ink for indicating errors on papers had a negative impact on children.

6. Letting Children and Adolescents Know That They Are Special and Appreciated

In my workshops I often ask the audience, "In the past week or two, what have you done to help another person to feel special and appreciated?" I pose this question since I have found that although most of us are thrilled to receive a note or phone call of appreciation, many well-intentioned people do not make use of opportunities to show appreciation. I am reminded of an article I once read that noted that many adults have a "praise deficit." We must make certain we find ways to appreciate angry or sad youngsters, especially since they often feel scared, vulnerable, and not well-liked. Self-esteem, motivation, hope, and resilience are nurtured when we convey appreciation and encouragement to students, when we become the charismatic adults in their lives. Words and actions that communicate encouragement are always welcome and energizing. They are vital for defiant children, many of whom are burdened with anger and self-doubt, and may not at first accept the positive feedback. We must persevere, however, and never forget that even a seemingly small gesture of appreciation can generate a long-lasting positive effect. The following are examples:

Connecting outside of school. I met a high school teacher who had more than 150 students in his classes and he planned to call each of them at least twice at home in the evening during the school year to find out how they were doing. He told me that the practice took only about 7- to 8-minutes an evening, but had very positive effects, including students being more respectful and more disciplined in class, and doing their homework more regularly. This particular teacher was gifted in knowing how to help his students feel welcome and appreciated.

Becoming a charismatic adult or mentor. Research indicates that when students have at least one adult in school whom they feel cares about them and is an advocate for them, they are less likely to be violent or drop out and more likely to attend (Brooks, 1991).

School-wide recognition. Schools can hold recognition assemblies not just to acknowledge the achievements of students with high grades, but also to spotlight the islands of competence of students whose grades do not qualify for the honor role, but who have made other contributions to the school environment.

Concluding Thoughts

Anger and resistance in youths present major challenges for educators. I believe that if we use a strength-based model guided by empathy, self-esteem, self-discipline, motivation, resilience, and hope we will be able to create nurturing school environments that reach an increasing number of these youngsters and help direct them toward a more constructive path in life. A review of questions to assess whether we have provided a positive school climate for each student may be found in this chapter's Appendix. Educators involved in psycho-educational case studies and/or behavior intervention planning may find this Appendix of valuable assistance.

As educators we must remember that we have a great privilege, namely, that of having an impact on the life of a developing youngster. Having this privilege, we must always ask, "Are we using it in the most effective way?" Educating angry, alienated, at-risk students presents many challenges and struggles, but out of these can emerge children who become very productive, resilient adults. Although it is not an easy task, all of us are capable of becoming the charismatic adults in children's lives. It is our gift to the next generation.

References

Adelman, H., & Taylor, L. (1983). Enhancing motivation for overcoming learning and behavior problems. *Journal of Learning Disabilities*, *16*, 384-392.

Baumeister, R. F. (1996). Should schools try to boost self-esteem? *American Educator*, *20*, 14-19.

Beardslee, W. R. (1989). The role of self-understanding in resilient individuals: The development of a perspective. *American Journal of Orthopsychiatry*, *59*, 266-278.

Beck, A. T. (1986). Hopelessness as a predictor of eventual suicide. *Annals of the New York Academy of Science*, *487*, 90-96.

Bernstein, N. I. (1996). *Treating the unmanageable adolescent*. Northvale, NJ: Jason Aronson.

Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service.

Brooks, R. B. (1987). Storytelling and the therapeutic process for children with learning disabilities. *Journal of Learning Disabilities*, *20*, 546-550.

Brooks, R. B. (1988). Fostering self-esteem and caring: The taming of anger. In P. Vesin (Ed.), *Proceedings of the International Conference on Children and the Media: Channeling Children's Anger* (pp. 127-136). Paris: International Children's Center.

Brooks, R. B. (1991). *The self-esteem teacher*. Loveland, OH: Treehaus Communications.

Brooks, R. B. (1992). Self-esteem during the school years: Its normal development and hazardous decline. *Pediatric Clinics of North America*, *39*, 537-550.

Brooks, R. B. (1994). Children at risk: Fostering resilience and hope. *American Journal of Orthopsychiatry*, *64*, 266-278.

Brooks, R. B. (1997). A personal journey: From pessimism and accusation to hope and resilience. *Journal of Child Neurology*, *12*, 1-9.

Brooks, R. B. (1998). Parenting a child with learning disabilities: Strategies for fostering self-esteem, motivation, and resilience. In T. Citro (Ed.), *The experts speak* (pp. 25-45). Waltham, MA: Learning Disabilities Association of Massachusetts.

Brooks, R. B. (1999a). Creating a positive school climate: Strategies for fostering self-esteem, motivation, and resilience. In J. Cohen (Ed.), *Educating minds and hearts: Social emotional learning and the passage into adolescence* (pp. 61-73). New York: Columbia Teachers College Press.

Brooks, R. B. (1999b). Fostering resilience in exceptional children: The search for islands of competence. In V. Schwean & D. Saklofske (Eds.), *Handbook of psychosocial characteristics of exceptional children* (pp. 563-586). New York: Academic/Plenum Publishers.

Brooks, R. B., & Goldstein, S. (2001). *Raising resilient children*. Chicago: Contemporary Books.

Brooks, R. B. (author), & Gunther, N. (producer) (1997). *Learning disabilities and self-esteem. Look what you've done! Stories of hope and resilience*. [Educational guide and videotape]. (Available from PBS VIDEO, Alexandria, Virginia (800) 344-3337)

Charney, R. S. (1991). *Teaching children to care: Management in the responsive classroom*. Greenfield, MA: Northeast Foundation for Children.

Chess, S., & Thomas, T. (1987). *Know your child*. New York: Basic Books.

Curwin, R. L. (1992). *Rediscovering hope: Our greatest teaching strategy.* Bloomington, IN: National Educational Service.

Curwin, R. L., & Mendler, A. N. (1988). *Discipline with dignity.* Reston, VA: Association for Supervision and Curriculum Development.

Deci, E. L., & Chandler, C. (1986). The importance of motivation for the future of the LD field. *Journal of Learning Disabilities, 19,* 587-594.

Deci, E. L., & Flaste, R. (1995). *Why we do what we do: Understanding self-motivation.* New York: Penguin Books.

Deci, E. L., Hodges, R., Pierson, L., & Tomassone, J. (1992). Autonomy and competence as motivational factors in students with learning disabilities and emotional handicaps. *Journal of Learning Disabilities, 25,* 457-471.

Dicintio, M. J., & Gee, S. (1999). Control is the key: Unlocking the motivation of at-risk students. *Psychology in the Schools,* 36, 231-237.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools.* Washington, DC: U.S. Department of Education.

Gardner, H. (1983). *Frames of mind.* New York: Basic Books.

Glasser, W. (1997). A new look at school failure and school success. *Phi Delta Kappan, 78,* 596-202.

Goldstein, S. (1995). *Understanding and managing children's classroom behavior.* New York: Wiley.

Goldstein, S., & Mather, N. (1998). *Overcoming underachieving: An action guide to helping your child succeed in school.* New York: Wiley.

Goleman, D. (1995). *Emotional intelligence.* New York: Bantam.

Greene, R. (1998). *The explosive child.* New York: Harper Collins.

Heath, D. H. (1999). *Schools of hope: Developing mind and character in today's youth.* Bryn Mawr, PA: Conrow Publishing House.

Hechtman, L. (1991). Resilience and vulnerability in long term outcome of attention deficit hyperactivity disorder. *Canadian Journal of Psychiatry,* 36, 415-421.

Hornbeck, D. W. (1989). *Turning points: Preparing American youth for the 21st century.* New York: Carnegie Council on Adolescent Development.

Ingersoll, B. D., & Goldstein, S. (1995). *Lonely, sad and angry: A parent's guide to depression in children and adolescents.* New York: Doubleday.

Jacobson, L. (1999). Three's company: Kids prove they have a place at the parent-teacher conference. *Teacher Magazine, 11,* 23.

Katz, M. (1994, May). From challenged childhood to achieving adulthood: Studies in resilience. *Chadder,* pp. 8-11.

Katz, M. (1997). *On playing a poor hand well.* New York: Norton.

Kohn, A. (1993). Choices for children: Why and how to let students decide. *Phi Delta Kappan, 75,* 8-20.

Lerner, B. (1996). Self-esteem and excellence: The choice and the paradox. *American Educator, 20,* 14-19.

Levine, M. D. (1994). *Educational care: A system for understanding and helping children with learning problems at home and in school.* Cambridge, MA: Educators Publishing Service.

Malicky, G., Shapiro, B., & Mazurek, K. (1999). *Building foundations for safe and caring schools: Research on disruptive behaviour and violence*. Edmonton, Alberta: Duval House Publishing.

Mecca, M. A. (1990). *Toward a state of esteem: The final report of the Task Force to Promote Self-Esteem and Personal and Social Responsibility*. Sacramento, CA: California State Department of Education.

Mendler, A. N. (1992). *What do I do when ...? How to achieve discipline with dignity in the classroom*. Bloomington, IN: National Educational Service.

Rademacher, J. A., Callahan, K., & Pederson-Seelye, V. (1998). How do your classroom rules measure up? Guidelines for developing an effective rule management routine. *Intervention in School and Clinic, 33*, 284-289.

Rief, S., & Heimburge, J. (1996). *How to reach and teach all students in the inclusive classroom*. West Nyack, NY: The Center for Applied Research in Education.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147*, 598-611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*, 316-331.

Segal, J. (1988). Teachers have enormous power in affecting a child's self-esteem. *The Brown University Child Behavior and Development Newsletter, 4*, 1-3.

Shure, M. (1994). *Raising a thinking child*. New York: Holt.

Strahan, D. (1989). Disconnected and disruptive students. *Middle School Journal, 21*, 1-5.

Weiner, B. (1974). *Achievement motivation and attribution theory*. Morristown, NJ: General Learning Press.

Werner, E. E. (1993). Risk, resilience, and recovery: Perspectives from the Kauai Longitudinal Study. *Development and Psychopathology, 5*, 503-515.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, NY: Cornell University Press.

Wexler, D. (1991). *The adolescent self: Strategies for self-management, self-soothing, and self-esteem*. New York: Norton.

Appendix

Guideposts to Providing a Positive School Climate for Students

I. Helping students to feel they belong, are connected, and are welcome in the school.

- Is there at least one staff member whom the student believes cares about him or her? How is this caring communicated to the student?
- What are strategies that teachers might use to help this student feel they are genuinely interested in him or her?
- Is this student accepted by other students? If so, who are these other students?
- If the student is isolated, what can be done to help this student develop closer relationships with other students?

II. Fostering self-determination and helping students to have a sense of ownership.

- What choices would this student say he or she has had in the past few months in school?
- What decisions would the student say he or she has made about his or her educational plan during this school year?
- Is the student invited to individualized education program (IEP) meetings and parent conferences? If so, who prepares the student for what will occur in the meeting and what will be expected of the student?
- Does the student have an opportunity to discuss issues and possible solutions pertaining to his or her school program?
- If the student is not in attendance at IEP meetings and parent conferences, is the student asked what he or she would like to have discussed at the meeting or conference and are suggestions elicited from the student?
- If the student is not in attendance at the meeting or conference, who will meet with the student to discuss what occurred?
- If the student is on a contract, does the student feel he or she was an active participant in the development and implementation of the contract?

- If educational and/or psychological testing was conducted, did the student receive feed back about the results of the testing, both in terms of areas of strength and areas of weakness?

- Does the student have a clear understanding of why certain interventions have been implemented?

III. **Identifying, reinforcing, and displaying a student's islands of competence.**

- What are the student's competencies or strengths?

- Has anyone asked the student what he or she believes are his or her areas of strength?

- How are these strengths displayed in the school setting (e.g., if a student is an excellent artist, is the student's artwork displayed in school)?

- If the student has an IEP, are the areas of strength listed and does it also indicate how these strengths will be used?

- What does this student contribute to the school? One of the best ways to help students to feel competent is for them to feel that they are making a contribution to the school (i.e., they have at least one responsibility that helps them to feel that, because they are in the school, the school is a better place).

IV. **Identifying a student's coping strategies.**

- What are the main ways this student copes with school and with mistakes (e.g., asking for help, being a bully, quitting, being a class clown)?

- Does this student's main ways of coping lead to positive or negative outcomes?

- How can we help this student to develop more adaptive coping strategies (e.g., asking for and accepting assistance, developing new strategies for learning)?

5

危機

Administrative Considerations in Preventing and Responding to Crisis: A Risk Management Approach

Ted Feinberg, Ph.D.
National Association of School Psychologists

Susan Jacob, Ph.D.
Central Michigan University

In 1996-1997, about 10 of every 1,000 students ages 12 through 18 were victims of serious violent crimes at school or on their way to or from school. Fortunately, some national statistics suggest a decline in violent crime in schools across the country in recent years (U.S. Department of Education and Department of Justice [DOE hereafter], 1999). Coincident with this overall decline in violent school crime, however, there has been an increase in high-profile crisis events, such as the school shootings that occurred in Pearl, Mississippi, and West Paducah, Kentucky in 1997; Jonesboro, Arkansas, in 1998; and Littleton, Colorado, in 1999. Such tragic events have had a profound emotional ripple effect on schools, students, and families across the country. Students are more fearful at school than in the past (DOE, 1999), and lawmakers and parents have insisted that schools increase their efforts to prevent school violence. In addition, victims of crimes at school are demanding that "schools either assure a safe and orderly school environment or compensate them for their injuries" (Rapp, Carrington, & Nicholson, 1992, p. 17). Lawsuits against schools "are becoming increasingly common as individuals vent their frustration and demand significant financial damages for unsafe conditions on school campuses" (Greenbaum, Gonzalez, & Ackley, 1993, p. 35).

In this chapter, we discuss school district liability associated with student-on-student violence and student suicide and provide risk management suggestions. The chapter begins with an overview of the term civil liability. Then we discuss lawsuits against school districts under state laws, constitutional torts, and lawsuits under federal antidiscrimination legislation.[1] We do not provide a comprehensive or detailed legal analysis of cases; we instead provide examples of cases to illustrate key legal terms and concepts. The cases also serve to inform school professionals about the types of actions (or failure to act) that might result in a successful lawsuit against the school when an injured student seeks compensation in court. The chapter concludes with a series of risk management recommendations.

Civil Liability

Civil liability, simply stated, "means that one can be sued for acting wrongly toward another or for failing to act when there was a recognized duty to do so" (Hopkins & Anderson, 1985, p. 21). Civil liability rests within the basic framework of the law of tort. A tort is a civil wrong not involving contracts. Tort law "offers remedies to individuals for harm caused by the unreasonable conduct of others" (Evans, 1997, p. 183). It is a complex area of law.

The most common tort committed by school personnel is negligence (Evans, 1997). In general, in tort cases the court considers four questions: (a) Did injury occur? (b) Was there a duty recognized in law for the actor (school) to protect the student from harm? (c) Was there a breach of duty (i.e., did school personnel do what a reasonable and prudent professional would have done in similar circumstances)? (d) Is there a promixate cause (causal) relationship between the injury and the breach of duty?

Lawsuits Against Schools Under State Laws[2]

Doctrine of Nonliability

When students are injured as a result of student-on-student violence and the injured student seeks vindication in court, the student-victim is most likely to file a lawsuit in state court (Schill, 1993). Generally, under state statutory law and common law, schools have a duty to maintain order and discipline and to protect students from foreseeable harm.

However, public schools are an arm of state government. Historically, under common law, a school district could not be held liable for torts committed by the district, officials, or other employees (Reutter, 1994). In some states, the immunity of school districts was originally based on the old English doctrine of *sovereign immunity*: "the King (state) can do no wrong; you can't sue the King." The sovereign immunity defense could be invoked for government (school) acts that were discretionary. Broadly speaking, *discretionary* means acts by school personnel in their official roles (Reutter, 1994; Wood & Chestnutt, 1995). In other states, immunity of school districts was based on the fact that state law provides no funds for the payment of damages; funds for education could not be diverted to pay legal claims (Reutter, 1994).

Currently, most states have used either legislation or case law to modify the doctrine of school district immunity. Exceptions to the doctrine of immunity vary from state to state, however, making it extremely difficult to generalize about the kinds of tort actions that will be successful against school districts in various states. Immunity usually exists to the extent that the school's or school boards liability insurance does not cover the particular injury suffered (Schill, 1993, p. 1). This means that, in many states, state legislation or case law permits lawsuits against school districts, but allows recovery only up to the limits of the school's liability insurance (see Reutter, 1994).

Whether or not individual school employees can be sued is also a complicated matter, determined by state legislation and case law. Michigan courts, for example, have typically held teachers and other individual school employees immune from liability during performance of duties within the scope of their employment. School districts, however, may discipline such individuals for inappropriate actions.

Factors the Courts May Consider

When a student is harmed by student-on-student violence, the victim is most likely to sue the school district and/or employed personnel (i.e., the teacher, principal, and school board) for failure to provide adequate security or for negligent supervision. Such lawsuits generally allege that the school negligently failed to provide adequate security or supervision, allowed an incident to occur, and thus caused the injury by allowing the incident to occur. To succeed in court, the plaintiff must allege and prove that school officials had a duty to prevent injuries to the student, the officials breached the duty, the breach caused harm, and the plaintiff suffered injury as a result (Schill, 1993; Wood & Chestnutt, 1995). Lawsuits following a student suicide have claimed that the school had knowledge that the student was suicidal and negligently failed to inform the parents (Eisel v. Board of Education of Montgomery County, 1991).

As noted above, when a lawsuit is filed against the school following student suicide or student-on-student violence, the first consideration of the court is whether school officials had a duty to prevent an injury. In making such a determination, the court is likely to consider whether the injury was *foreseeable*. A school official may be held to have foreseen harm if he has "actual or constructive knowledge of a hazardous condition" (Wood & Chestnutt, 1995, p. 426). Although school personnel have a legal duty to protect pupils in their schools from reasonably foreseeable risk of harm, they are not considered "insurers of pupils' safety" (Reutter, 1994, p. 377). A school is not liable for every thoughtless or careless act by which one student may injure another (Lawes v. Board of Education of the City of New York, 1965). Schools are not likely to be held liable when spontaneous, unforeseeable acts by students result in injury (Wood & Chestnutt, 1995).

If the injury was foreseeable, the court addresses the second consideration, namely, whether there was *responsible prudent action* on the part of those involved. If the school has knowledge of a specific danger, the school has a duty to take reasonable precautions (Wood & Chestnutt, 1995). Failure to take reasonable precautions is a breach of the school's duty to protect students. Negligent conduct "may involve doing something that a reasonably prudent person would not do under the circumstances or not doing something that a reasonably prudent person would do under the circumstances"

(Reutter, 1994, p. 376-377). Evaluation of the specific circumstances is critical to the determination of the boundaries of prudent action (Reutter, 1994).

The third consideration is whether there was a causal connection between a breach of duty and the injury. For a court to find a school liable for injury to a student by a student, the negligent conduct must be the *proximate* (or near) cause of the injury; that is, the injury must be directly attributable to the negligent act. A proximate cause of injury is "that which, in a natural and continuous sequence, unbroken by any efficient intervening cause, produces injury, without which the result would not have occurred (Black, 1983, p. 641).

To illustrate the concepts of foreseeability, reasonable prudent action, and proximate cause of harm, we provide two case examples from state courts. It should be noted that the court considers the same factors in the constitutional torts discussed later in this chapter. In Mirand v. Board of Education of the City of New York (1994), a female high school student kicked and then verbally threatened to kill the plaintiff, a fellow student. Following this brief exchange in the hall, the plaintiff appropriately tried to seek intervention by school security, but no security personnel were present in their office. She also notified a teacher of the threat in efforts to prevent a possible confrontation. Thus, the plaintiff tried at least two different approaches to notify school personnel of the threats against her. As was anticipated, at dismissal time, the threatening student attacked the plaintiff and caused injuries, some of which were permanent. Even if the school was unaware of the assailant's propensity for violence, the injury was foreseeable because school was on notice of at least one incident of attempted assault and threats of future injury.

The school's negligence here was twofold. First, despite having a security plan that required the posting of guards throughout the school at dismissal times, no security guards were available in their office or at their appropriate posts. Second, the teacher who learned of the threats took no further action to notify security, the police, or other personnel. Although on notice of an imminent foreseeable danger to the plaintiff, the school "did nothing reasonably calculated to protect her from that danger" (p. 50). The court noted that the school was negligent not only because of its failure to comply with its own security plan, but also because of the "complete absence of security or supervisory personnel at a time and place when vigilance was absolutely essential" (p. 51). The absence of supervision was seen as the proximate cause of the plaintiff's injuries. Because of the school's direct notice and failure to prevent injury, the school district was held liable for damages.

In contrast, in Kennedy v. Seaford Union Free School District No. 6 (1998), one student physically assaulted and injured another student at the school. The injured student alleged that the school was negligent in its supervision of the aggressor student and that negligent supervision was the proximate cause of injury. In this case, however, the aggressor student and the plaintiff were friends, the aggressor had no history of prior acts of violence against fellow students, and the act of violence was seen as impulsive and unanticipated (p. 575). The school was not held liable.

Constitutional Torts

It is important to note that an increasing number of student-on-student violence lawsuits are being filed in federal court under Section 1983 of the Civil Rights Act of 1871. Under Section 1983, any person whose constitutional rights have been violated by a government official performing discretionary functions may sue for damages in federal court, and the official may be held liable for damages. Section 1983 also allows suits for the violation of rights protected by federal statutory law.

Under Section 1983, the government (school) and its employees may have only "qualified immunity" from lawsuits, and parents can recover attorney fees if they prevail in their suit. Thus, while individual school district employees may have immunity from liability suits under state law, they have only "qualified immunity" under Section 1983. The standard for qualified immunity applicable to government (school) officials is as follows: " … government officials performing discretionary functions, generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known" (Harlow v. Fitzgerald, 1982, p. 2737).

Some student-on-student violence lawsuits filed under Section 1983 are based on the claim that the state (school) failed to protect the victim from injury and that the victim's constitutional right to be free from unwarranted intrusions on personal security was violated. The right to be free from unwarranted intrusions on personal security is a liberty interest protected by the 14th Amendment (Ingraham v. Wright, 1977). Failure to take appropriate steps to prevent student suicide may violate a parent's constitutionally protected liberty interest in the companionship of their child (Kelson v. City of Springfield, 1985).

Two different legal theories have been advanced in support of Section 1983 claims against public schools by victims of student-on-student violence and by families of students who committed suicide: the special relationship doctrine and the state-created danger doctrine (Schulze & Martinez, 1995).

Special Relationship Doctrine

The due process clause of the 14th Amendment states: "No State shall … deprive any person of life, liberty, or property, without due process of law." The 14th Amendment protects citizens from wrongful infringement of their rights by the government. It does not create a duty for government to protect citizens from wrongful infringement of their rights by private actors (DeShaney v. Winnebago County Department of Social Services, 1989). The 14th Amendment "is phrased as a limitation on the State's power to act, not as a guarantee of certain minimal levels of safety and security" (DeShaney, 1989, p. 195). However, case law has recognized that certain circumstances may create an affirmative duty for the government to protect citizens. When a state limits an individual's freedom to act on his or her own behalf, then it assumes some responsibility for the individual's safety and well-being (Youngberg v. Romeo, 1982). The specific circumstances that create a "special relationship" between government and a citizen giving rise to a duty to protect are not completely clear at this time.

In 1989, the Supreme Court decided DeShaney v. Winnebago County Department of Social Services (1989). This was a Section 1983 case filed against the social services department for its failure to protect a child, Joshua, from his abusive father. Although social services knew Joshua experienced ongoing and serious physical abuse, the caseworker took no action to remove the boy from his abusive home. After Joshua was severely beaten by his father and suffered permanent, serious brain damage, his mother filed a Section 1983 lawsuit against social services. Her suit claimed that social services had violated Joshua's constitutional right to be free from body injury by their negligent failure to protect him. She claimed that social services had promised to protect Joshua and thereby assumed a "special relationship" to him, giving rise to a duty to protect.

The court in DeShaney issued a very narrow interpretation of "special relationship," suggesting that the state must have physical custody of the victim before an affirmative duty to protect arises:

> The affirmative duty to protect arises not from the State's knowledge of the individual's predicament or from its expressions of intent to help him, but from the limitation which it has imposed on his freedom to act on his own behalf ... In the substantive due process analysis, it is the State's affirmative act of restraining the individual's freedom to act on his own behalf—through incarceration, institutionalization, or other similar restraint of personal liberty—which is the "deprivation of liberty" triggering the protections of the Due Process Clause, not its failure to act to protect his liberty interests against harms inflicted by other means. (DeShaney, 1989, p. 200)

Section 1983 lawsuits since DeShaney have generally not been able to establish a special relationship between school and pupil that gives rise to a constitutionally based affirmative duty to protect. The courts have not viewed compulsory school attendance laws as a restraint on individual liberty giving rise to a special relationship and affirmative duty to protect (for example, see D.R. by L.R. v. Middle Bucks Area Vo. Tech. School, 1992).

State-Created Danger Doctrine

The Court in Deshaney left open the possibility that a duty to protect might be recognized when the state puts a person in danger:

> While the State may have been aware of the dangers that Joshua faced in the free world, it played no part in their creation, nor did it do anything to render him more vulnerable to them. That the State once

> took temporary custody of Joshua does not alter the analysis, for when it returned him to his father's custody, it placed him in no worse position than that in which he would have been had it not acted at all … (DeShaney, 1989, p. 200).

Some, but not all, federal courts have recognized the *state-created danger theory* as creating a constitutional duty for schools to protect a pupil from private actors when school actions create a dangerous situation or make a pupil more vulnerable to danger (Schultz & Martinez, 1995). As Schultz and Martinez note, the plaintiff must prove several elements in order to prevail under the state-created danger theory and hold the school district liable under Section 1983: the school must have affirmatively acted to create the danger or render the student more vulnerable to danger, the danger to the student that is created or enhanced by the school must encompass an immediate threat of harm, and the school defendants must have been deliberately indifferent in failing to adequately protect the plaintiff from the danger they created. *Deliberate indifference* suggests intentional or reckless conduct, indifference that "shocks the conscience." Two case examples follow.

Armijo v. Wagon Mound Public Schools Board (1998) was a case concerning a 16-year-old special education student who committed suicide after being sent home from school to an empty house. His family filed suit against the school district after his death, alleging violations of their deceased son's civil rights. The boy was classified as learning disabled and had a history of emotional problems, including impulsivity, depression, and threats of suicide. On the day of his death, he told the teacher's aide that "I'd be better off dead," and both his counselor and teacher's aide knew he had access to firearms at home. The boy was suspended after he harassed an elementary school child and then verbally threatened the teacher who reported the incident. The principal instructed the school counselor to drive the boy home, although the principal and counselor were both aware that neither parent was at home, and neither the principal nor counselor informed the boy's parents about his removal from school. This action was contrary to the school's suspension policy requiring students to be kept in in-school suspension if no parent is at home. The boy's parents found their son dead from a self-inflicted gunshot wound to the chest when they returned home later that day.

In its discussion of the case, a federal court noted that state officials can be liable for acts of third parties where those officials created the danger that caused harm. The court made the following factual inferences based on the evidence presented: (a) the student was a special-education student who had expressed threats of suicide; (b) the conduct of the principal and counselor put the boy at substantial risk of serious, immediate, and proximate harm by suspending him from school, which caused him to become distraught and threaten violence, and then taking him to his home and leaving him alone with access to firearms; (c) the principal and counselor had some knowledge the boy was suicidal, distraught, and had access to weapons; (d) the principal and counselor acted recklessly in conscious disregard of the risk of suicide; and (e) such conduct, if true when viewed in total, possibly could be construed as conscience-shocking, depending on context as determined after a full trial. The court also noted that the facts, if true, could be construed to show the actions of the counselor and principal increased the risk of harm to the boy. The federal court did not determine liability; it only determined that there were sufficient facts (when viewed in a light favorable to the plaintiff) and legal reasons not to hold the principal and counselor immune from liability, and the case was referred to another court for further proceedings.

Dorothy J. v. Little Rock School District (1993) was a suit filed on behalf of a special-needs pupil, Brian, after another student, Louis, raped him at school. Louis was a student with known violent tendencies who was placed in a program with mentally impaired pupils. Two years after the initial placement, Louis attacked and raped his classmate, Brian. The court ruled in this case that the state (school) did not create the danger to Brian because there was no clear causal link between Louis' placement in the school program and his attack on his classmate.

Lawsuits Under Federal Antidiscrimination Legislation

Federal antidiscrimination law protects students from harassment and hate crimes based on race, color, national origin, sex, and disability, and makes schools responsible for taking steps to remedy harassment of students (see Chapter 34, Legal and Ethical Issues in Crisis Prevention and Response in Schools). Prior to 1999, some courts had held that Title IX of the Education Amendments of 1972 did not apply to student-on-student sexual harassment. In 1999, the U.S. Supreme Court heard Davis v. Monroe County Board of Education, a case in which a pupil who was the victim of student-on-student sexual harassment filed suit against the school district under Title IX. The case was brought by the mother of a girl who, as a fifth-grader, was subjected to a prolonged pattern of sexual harassment by one of her fifth-grade classmates. The unwanted sexual advances included attempts to touch the girl's breasts and genital areas, and statements such as "I want to get in bed with you" and "I want to feel your boobs" (p. 1666). The girl reported each incident to her mother and classroom teacher. The teacher and school administrators did not respond to complaints from the mother, the school did not take steps to stop the harassment by disciplining the boy or separating the two (e.g., changing the girl's seat in class so she did not have to sit next to him), and the teacher did not allow other girls to report their complaints about the boy to the principal. The boy was eventually charged and convicted in juvenile court of sexual battery against the girl.

The Court ruled that Title IX applies to student-on-student sexual harassment. In her opinion, Justice O'Connor stated that "damages are not available for simple acts of teasing and name-calling among school children" but rather for behavior "so severe, pervasive, and objectively offensive" (p. 1675) that it denies its victims the equal access to education as guaranteed under Title IX. She went on to state that the school officials must have known of the harassment and, acting with "deliberate indifference," failed to take reasonable steps to stop it. The case was returned to a lower court for determination of the school district's liability.

The Davis (1999) ruling suggests that, to avoid liability under federal antidiscrimination legislation, schools must take reasonable steps to prevent student-on-student harassment based on race, color, national origin, sex, and disability. Such preventative actions are necessary to ensure an environment in which all children have equal opportunities to learn, and because student-on-student harassment may be a precursor to even more serious acts of sexual assault or physical violence (see U.S. Department of Education & Bias Crimes Task Force of the National Association of Attorneys General, 1999).

Risk Management for Schools

It is important for educators to temper their fear of lawsuits with recognition of the fact that the courts have generally supported the good faith efforts of schools to provide a safe and effective learning environment (James, 1994). Schools have a general duty to supervise students and to take reasonable steps to protect students from school violence. However, as evident from cases reviewed here, school districts typically have not been held liable for injury resulting from spontaneous, unexpected violent acts. In situations in which there is a foreseeable danger to a student, schools are not likely to be held liable unless there is a failure to intervene in any substantive manner.

In this discussion of risk management as it relates to schools and crisis preparedness, we strongly believe that most school districts should implement the following procedures to foster a safe and effective learning environment for all children and reduce their risk exposure.

1. All school districts should have a comprehensive safe school plan that addresses violence prevention, intervention, and response (see Stephens, 1994). The plan should outline the district's philosophical position on violence prevention and preparedness as well as describe the procedures and personnel available to respond in the event that a crisis occurs. The plan should be developed by a school-community team, take into account the resources available to the district; and be consistent with federal, state, and local laws (Dwyer, Osher, & Warger, 1998).

2. As part of its safe school plan, districts should ensure that student discipline policies and practices foster a positive school climate and minimize the likelihood of student alienation and mistrust. School rules and regulations must be a reasonable exercise of the power of school authorities, related to the purpose of maintaining order and discipline, and be enforced in a fair and nondiscriminatory manner. Policies should be clearly stated and publicized, must not violate the legal rights of pupils or their parents, and should be implemented in ways that are respectful of the rights and dignity of individual students.

3. Every district should establish an incident reporting and tracking system to determine the nature and scope of crime and violence in their schools (Rapp et al., 1992) and implement policies that encourage staff and students to report incidents and concerns. This documentation allows the school to monitor its

progress toward reducing crime. In addition, concerns about school safety must be documented prior to the introduction of certain security measures (see Chapter 34, Legal and Ethical Issues in Crisis Prevention and Response in Schools).

4. Districts should ensure adequate staff orientation to district violence prevention and response policies and procedures and provide ongoing training for staff to improve violence-prevention efforts through curricular (e.g., teaching conflict resolution) and other interventions. Pulliam (1999) and Pitcher and Poland (1992) recommend that the violence-prevention component of a safe school plan include training for administrators and teachers on how to recognize and defuse potential violence. Training in how to manage verbal and physical aggression, and how to protect self and others from harm, is particularly important for staff who work with high risk groups such as students with behavior disorders. School staff should be clearly informed, however, that they are not expected or legally required to jeopardize their own safety by physically intervening in student fights or by attempting to disarm a student with a weapon (Pitcher & Poland, 1992).

5. The violence-prevention component should include written policies that protect students from harassment and specifically harassment and hate crimes based on race, color, national origin, sex, disability, and sexual orientation. The policy should specify how students, staff, and parents can report concerns about harassment and it should identify the school personnel responsible for ensuring that reasonable steps are taken to stop harassment and prevent future occurrences (see U.S. Department of Education & Bias Crimes Task Force of the National Association of Attorneys General, 1999).

6. The intervention component of the safe school plan should include written procedures for school personnel to follow if they suspect a student is potentially dangerous to others, to self, or is a victim of abuse. Threats of violence and suicide should be taken seriously. When it is suspected a student is suicidal, the student should be seen by a mental health professional with training in assessment of suicide lethality. When a student makes threats to harm others, procedures should ensure the student is seen for evaluation by a team knowledgeable of threat assessment. District policies should state that students may be seen by the school psychologist or other mental health professional without parental notice or consent to determine if the pupil is dangerous or in danger. If a pupil is determined to be a threat to self or others, school procedures should ensure that appropriate parties are informed of the situation (e.g., parents of a suicidal youth), and that there is a coordinated response, drawing on the resources of the school, family, and community as needed.

7. The job descriptions of school personnel should be written to include their likely roles in school violence prevention and crisis response (Pitcher &

Poland, 1992). As noted earlier in this chapter, school employees are more likely to be shielded from liability in lawsuits if they are acting within the scope of their authority.

8. School personnel who are expected to assume special roles in violence prevention or response (e.g., psychologists who assess suicide lethality) should receive verifiable training to assume those roles and be encouraged to consult with experts in situations in which the appropriate course of action is not clear. Law enforcement should be summoned in potentially dangerous situations such as a search for bombs. School staff who volunteer to assist in bomb searches should receive training about types of bombs, what they look like, where they might be hidden, and what to do if they locate a suspicious item (Poland & McCormick, 1999).

9. The crisis response component of the safe school plan should identify a school-based core team responsible for crisis management, trained to respond to unforeseeable events (Dwyer et al., 1998; Kelson v. City of Springfield, 1985). The plan should identify the individuals (or their alternates) who will be expected to take responsibility in a crisis situation (Pulliam, 1999). The response plan should provide a formal template that allows all members of the school district to be familiar with a previously agreed upon crisis protocol. It should identify links for medical, fire, and police emergency assistance and community mental health (Pulliam, 1999). Such planning reduces confusion and increases the potential for greater efficiency in crisis response. Pulliam (1999) reported that medical teams, law enforcement, and school officials were able to respond rapidly to the school shootings in Jonesboro, Arkansas, because they relied on a disaster management plan originally developed because Jonesboro is located on an earthquake fault-line.

10. The crisis response plan should be carefully coordinated with law enforcement. When a crime occurs on school grounds, the police are in charge (Pulliam, 1999). School officials should be prepared to assist police in their efforts to define the crime zone, find witnesses, preserve evidence, control the media, and manage ingress and egress (Pulliam, 1999). School district staff should be oriented to these concerns.

11. The crisis response plan should identify a trained spokesperson responsible for answering questions from the media to ensure that there is no disclosure of confidential information and that pupil, staff, and family privacy are respected.

12. The plan should emphasize the need for careful documentation of all steps taken to prevent violence and steps taken by the crisis team in the aftermath of a crisis situation. The purpose of logging in actions is to evaluate the steps taken and fine-tune existing procedures. In addition, if the school documents show it responded to concerns about potential violence or violent events, then the

school has a record that can be used if and when a court action requires the ability to recall how a situation was handled some time after the event has passed. This reduces the speculative aspect of such testimony rather significantly.

Conclusions

Generally, under state statutory law and common law, schools have a duty to maintain order and discipline and to protect students from foreseeable harm. When a school administrator becomes aware of a situation that poses a danger to students, he or she is obligated to take reasonable steps to prevent student injury. School administrators can best safeguard the well-being of students and protect their district from liability by developing comprehensive safe school plans that address violence prevention and response, ensuring that all school staff know what to do in situations involving threats or acts of violence by students, and ensuring that crisis response team members have appropriate training to assume their assigned roles.

120

References

Armijo v. Wagon Mound Public Schools, 159 F.3d 1253 (10th Cir. 1998).

Black, H. C. (1983). *Black's law dictionary* (5th ed.). St. Paul, MN: West Publishing.

Civil Rights Act of 1871, 42 U.S.C. § 1983.

Davis v. Monroe County Board of Education, 526 U.S. 629, 119 S.Ct. 1661, 1999 U.S. LEXIS 3452, 143 L.Ed. 2d 839, 67 U.S.L.W. 4329 (1999).

DeShaney v. Winnebago County Dept. of Social Services, 489 U.S. 189, 109 S.Ct. 998, 103 L.Ed.2d 249 (1989).

Dorothy J. v. Little Rock School District, 7 F.3d 729, 1993 U.S. App. LEXIS 26604 (8th Cir. 1993).

D.R. by L.R. v. Middle Bucks Area Vo. Tech. School, 972 F.2d 1364 (3rd Cir. 1992).

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education. Available Online: www.ed.gov/offices/OSERS/OSEP/earlywrn.html

Education Amendments of 1972, 20 U.S.C.S. § 1681 *et seq*. (LEXUS, 1999).

Eisel v. Board of Education of Montgomery County, 597 A.2d 447 (Md. 1991).

Evans, W. J. (1997). Torts. In C. J. Russo (Ed.), *The yearbook of school law 1997* (pp. 183-212). Dayton, OH: Education Law Association.

Greenbaum, S., Gonzalez, B., & Ackley, N. (1993). *Educated public relations: School safety 101*. Malibu, CA: National School Safety Center, Pepperdine University Press.

Harlow v. Fitzgerald, 457 U.S. 800, 102 S.Ct. 2727 (1982).

Hopkins, B. R., & Anderson, B. S. (1985). *The counselor and the law* (2nd ed.). Alexandria, VA: American Association for Counseling and Development.

Ingraham v. Wright, 430 U.S. 651, 51 L.Ed. 2d 711 (1977).

James, B. (1994). School violence and the law: The search for suitable tools. *School Psychology Review, 23*, 190-203.

Kelson v. City of Springfield, 767 F.2d 651 (9th Cir. 1985).

Lawes v. Board of Education of the City of New York, 16 N.Y.2d 302, 213 N.E.2d 677, 1965 N.Y. LEXIS 913, 266 N.Y.S.2d 364 (N.Y. 1965).

Kennedy v. Seaford Union Free School District No. 6, 250 A.D. 2d 574, 672 N.Y.S.2d 407, 1998 N.Y. App. Div. LEXIS 4937 (N.Y. 1998).

Mirand v. Board of Education of the City of New York, 84 N.Y.2d 44, 637 N.E.2d 263, 1994 N.Y. LEXIS 1345. 614 N.Y.S.2d 372 (N.Y. 1994).

Pitcher, G., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Pulliam, J. L. (1999). The attorney's role in responding to violence: A case study of Jonesboro, Arkansas. *School Law in Review 1999* (pp. 1-18). Alexandria, VA: National School Board Association.

Rapp, J. A., Carrington, F., & Nicholson, G. (1992). *School crime and violence victims' rights* (2nd ed.). Pepperdine, CA: National School Safety Center, Pepperdine University Press.

Reutter, E. E. (1994). *The law of public education* (4th ed.). Westbury, NY: Foundation Press.

Schill, K. (1993, Fall). Violence among students: Schools' liability under Section 1983. *School Law Bulletin*, pp. 1-11.

Schulze, E. W., & Martinez. T. J. (1996). Into the snakepit: Section 1983 liability under the state-created danger theory for acts of private violence at school. *West's Education Law Quarterly*, 5, 175-188.

Stephens, R. D. (1994). Planning for safer and better schools: School violence prevention and intervention strategies. *School Psychology Review*, *23*, 204-215.

U.S. Department of Education and Department of Justice. (1999). *School safety, annual report*. 1998. Washington, DC. (ERIC Document Reproduction Service No. ED 428 464).

U.S. Department of Education & Bias Crimes Task Force of the National Association of Attorneys General. (1999). *Protecting students from harassment and hate crime*. Available Online: www.ed.gov/offices/OCR/

Wood, R. C., & Chestnutt, M. D. (1995). Violence in U.S. schools: The problems and some responses. *West's Education Law Quarterly*, *4*, 413-428.

Youngberg v. Romeo, 457 U.S. 307 (1982).

Endnotes

[1] The chapter focuses on lawsuits filed following student injury at the hands of "private actors," that is, lawsuits following student-on-student violence and student suicide. It does not address student injury at the hands of "state actors," harm that results from violent acts by principals, teachers, or other school staff. It also, does not address professional malpractice suits against school psychologists and other school mental health practitioners. The authors are not attorneys and nothing here should be construed as legal advice.

[2] For a detailed discussion of cases and legal defenses, see Evans (1997) and Rapp et al. (1992).

6

Problem-Solving Training as a Form of Crisis Prevention

危機

Bonnie Aberson, Psy.D.
Miami-Dade County Public Schools (Miami, FL)

Myrna B. Shure, Ph.D.
MCP Hahnemann University

Recent school shootings have raised important questions for our society. What can we do to prevent children from using extreme violence to deal with their problems? Some school officials have argued for more discipline such as the zero tolerance policies. In an effort to deter students from bringing weapons to school and to curb violent threats and drug use, students are suspended or expelled the first time such behavior is witnessed. However, "… expelling troublemakers not only deprives the child of an education, but fails to address the real problem: the reason why the child brought a gun to school or committed a violent act" (Hyman, 2000, p. 4). In addition, we wonder whether a child returns to school angrier. Does sending children home give them skills to think about what they did, and what they could have done instead? This chapter describes how interpersonal cognitive problem solving (ICPS), combined with the emotional component of empathy, can help children think about what they do and help them make good decisions that would more likely result in positive, not negative, consequences.

Research has shown that, even in young children, harsh, authoritarian punishment does little to deter aggression, foster empathy, and guide positive prosocial behaviors such as cooperation, sharing, and teamwork (Barber, 1996; Straus, 1991). These findings are important because as early as preschool, antisocial and oppositional defiant behaviors (and lack of positive prosocial behaviors) are significant predictors of later, more serious outcomes such as violence, substance abuse, dropping out of school, and some forms of psychopathology (Parker & Asher, 1987; Roff, 1984).

Some research on predictors of violence suggests that violent behavior in adolescence and early adulthood may even be related to events in the birth canal, low resting heart rate, and low levels of arousal from infancy, coupled with maternal rejection and poor mother-infant bonding early in life (Raine, Brennan, & Mednick, 1997; Raine & Dunkin, 1990). With such early high-risk behaviors on the rise (Webster-Stratton &

Hammond, 1998), it is imperative that identification, prevention, and treatment of high-risk behaviors become high priorities among researchers and practitioners.

School psychologists are in a prime position to participate in prevention and treatment activities under the Individuals with Disabilities Education Act of 1997, which officially recognizes part of the responsibilities of the school psychologist as providing behavioral supports and interventions for children displaying early high-risk behaviors. This Act, in combination with the publication *Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer, Osher, & Warger, 1998), which was sent to educators nationwide as "… part of an overall effort to make sure that every school in this nation has a comprehensive violence prevention plan in place" (letter from Richard Riley and Janet Reno, p. i), means we now have important supports toward making violence-prevention programs a top priority in our schools.

What can we do for children and families early on to prevent violent behaviors and other crises in the schools? First, if underarousal coupled with maternal rejection is a predictor for some forms of violence, we might provide young mothers with the tools to stimulate their children to express their emotions appropriately during the preschool years. Second, we might also encourage mothers to listen to their children and to engage them in the process of thinking about what they do, and why they do it. Third, we might provide parents and teachers with the tools to empower children to use words in their thinking so they can be flexible enough to resolve problems with peers assertively in nonviolent ways.

Roadmap to This Chapter

We begin with Spivack's theory that there is a set of ICPS skills that mediate behaviors (Spivack & Shure, 1982), followed by early correlational research to identify specific ICPS skills that relate to behaviors in children. We then describe the intervention designed by the second author (Shure) for use by teachers and parents to test the mediating function of identified ICPS skills to behavior. Following original research by Shure and Spivack are subsequent evaluations by the first author (Aberson) and others, including ICPS with special-needs children such as those with attention-deficit/hyperactivity disorder (ADHD). Models of implementation in the classroom and the role of mental health professionals are described, as are ways to implement ICPS with parents.

Why Interpersonal Cognitive Problem Solving?

The theory behind the problem-solving approach to behavior, set forth by Spivack, is described in full in Spivack and Shure (1982). Highlights include:

> A key and common element in any theory of social adjustment or psychopathology is the quality of social relationships and capacity to cope with interpersonal problems. Experiencing interpersonal problems is

> viewed as a natural consequence of being human, since satisfactory social relationships are central to human development.
>
> How well one can solve one's interpersonal problems depends on a complex of interacting emotional and cognitive factors. However to appreciate fully the efficiency with which a person navigates a problem, it is necessary to understand how well he or she recognizes and thinks through the interpersonal situation. It is this process, manifest in a set of ICPS skills, that defines the human problem-solving capacity of relevance to adjustment. It is *how* one thinks that is crucial if one is to understand the likelihood of successful adjustment in the long run.
>
> There seems to be a grouping of ICPS process skills that mediates the quality of social adjustment. These skills are not the same as those defined by measures of abstract intelligence, or what IQ tests measure. (pp. 324-325)

Early Problem-Solving Research

Correlational Research: ICPS Skills and Behaviors

As a first step to test Spivack's theory that a set of interpersonal cognitive skills mediates behavior (called the ICPS/behavioral mediation theory), Spivack, Platt, and Shure conducted a series of studies to identify specific interpersonal cognitive skills that correlated with specific overt behaviors (Spivack, Platt, & Shure, 1976; Spivack & Shure, 1974). As measured by the Preschool Interpersonal Problem Solving (PIPS) test (Shure, 1992d), they found that, as young as age four (and regardless of measured IQ), inability to generate *alternative solutions* to age-appropriate interpersonal problems was the interpersonal cognitive skill most strongly related to impulsive behaviors such as physical and verbal aggression, inability to wait and cope with frustration, poor peer relationships, and lack of prosocial behaviors such as caring and sharing (Spivack et al., 1976; Spivack & Shure, 1974). These are the very behaviors that predict later violence, substance abuse, and other more serious outcomes. In addition, shy and withdrawn (inhibited) youngsters also were less able than better-adjusted youngsters to think of solutions to problems. Perhaps inhibited youngsters are unable, or unwilling, to express their feelings and solve everyday problems, and may hold in their feelings. If feelings of anger and frustration are not expressed, it is possible that inability to share them could lead to later depression, perhaps even suicide (e.g., Rubin, 1985), or violence (Lee, Zimbardo, & Berthoff, 1977).

Other ICPS skills found to be significantly correlated with these behaviors were *consequential thinking* (Shure, 1990) and *perspective-taking* (ability to take another's point of view and appreciate another's feelings, even if different from one's own). Beginning at age eight, *means-ends thinking* (the ability to plan sequential means to reach a stated goal, anticipate potential obstacles that could interfere with that goal, and appreciate that reaching a goal takes time) as a correlate of measured behaviors begins to emerge (Shure, 1982; Shure & Spivack, 1972). Others have confirmed these correlational findings across the life span in both low- and middle-income populations (reviewed in Spivack & Shure, 1982).

Another dimension of social competence is the model of information processing believed to be necessary for adequate social functioning. Crick and Dodge (1994) found, for example, that aggressive boys were more likely than less aggressive peers to perceive ambiguous acts as hostile and, without gathering further information or reading facial expressions or nonverbal cues, they reacted in kind. In addition, Dodge, Pettit, McClaskey, and Brown (1986) found that children who were able to generate nonaggressive strategies to a hypothetical situation, who evaluated incompetent responses negatively, and who demonstrated skill in role-playing appropriate responses were rated as more successful in their ability to enter peer groups.

In summary, the correlational research findings suggest that, as early as age four, an identified set of ICPS skills can distinguish socially adjusted and interpersonally competent children. The skill most strongly related to behaviors is alternative solution thinking, followed by consequential thinking, and perspective-taking. Beginning at age eight, means-ends thinking is also a significant predictor of measured behaviors. How children choose solutions available to them appears to be associated, in part, with how they perceive the motivations of others.

Applied Research: Testing the ICPS/Behavioral Mediation Hypothesis

The assumption drawn from the above studies is that individuals showing interpersonal behavioral difficulties often suffer from ICPS deficiencies. It seems logical that one who can accurately read nonverbal cues in relation to how others feel, who can conceptualize a variety of solutions and potential consequences of his or her actions (including people's feelings), and who can plan ahead is less likely to suffer the frustration of repeated failure and possible subsequent maladaptive functioning.

Whether availability of ICPS skills is an antecedent condition to adjustment cannot, however, be ascertained from correlational studies alone. To test Spivack's earlier stated ICPS/behavioral mediation theory, intervention was created to investigate a linkage between ICPS ability and behavioral adjustment by experimentally altering ICPS skills, and then observing changes in the child's display of behaviors related to ICPS skills. If ICPS ability does mediate such behaviors, we would be able to identify those ICPS skills that play the most significant role in behavioral adjustment and interpersonal competence, which would form the basis for a new approach to prevention of high-risk behaviors in children. Support for the ICPS/behavioral mediation theory would be manifest if those children who would most improve in the trained ICPS skills would be the same youngsters who would most improve in measured overt behaviors, independent of IQ. We begin by describing the interventions, then discuss the research and service evaluations of their impact on interpersonal thinking and behaviors.

A Model Problem-Solving Training Program

In the early 1970s, the second author (Shure) began piloting games and exercises to enhance ICPS skills with inner-city four-year-olds, first with a small group of children, then with four teachers who trained the children in their classrooms. Since that time, systematic research studies and service evaluations have been conducted with thousands of children from a variety of income and ethnic groups, including special-needs youngsters from preschool through 12 years of age.

Preschool, Kindergarten, and the Primary Grades

The approach of the program is to teach children *how* to think, not what to think, in ways that will help them successfully resolve interpersonal problems. The aim is to help children develop a problem-solving style of thought that will guide them when coping with typical, everyday problems.

Originally called Interpersonal Cognitive Problem Solving, or ICPS, and now called I Can Problem Solve (also ICPS), the training manual for preschool (Shure, 1992a) consists of sequenced games and dialogues, which teach three levels of language and thinking that our research found to be related to behavioral adjustment prior to training. The first level consists of games and dialogues to teach basic word concepts that help set the stage for later problem-solving thinking. For example, in preschool the word pairs *is/not*, and *might/maybe* are taught in game form so children can later think about whether an idea *is* or *is not* a good one in light of what *might* happen next. Words such as *same* and *different* are taught so youngsters can later see, for example, that hitting and kicking are kind of the *same* because they can both hurt someone, and then think of a *different* way to solve the problem. As children move into kindergarten and the primary grades, word pairs such as *before/after* and the concept *if-then* are added (Shure, 1992b). These words help them later think of consequences to acts by first recognizing, for example, that "*If* I hit him *before* he hits me, *then* he *might* hit me back," or "He hit me *after* I hit him." As noted by Vygotsky (1962), children who are guided by adults to unite thought and language can better regulate their behavior. Although some children already know these words, their repetition in game form (such as, "This *is* a table, it is *not* a giraffe," "I brush my teeth *after* I get out of bed in the morning, *not before*") helps to establish their later use in an interpersonal context.

After two to three weeks of daily games and exercises aimed at developing early word concepts, attention turns to the next level of the program, that of *pre-problem-solving* thinking skills. With an understanding of words that designate feelings, such as *happy*, *sad*, *angry*, and *afraid* in preschool, and the addition of words such as *proud*, *frustrated*, *worried*, and *relieved* in kindergarten, it is possible to teach that *different* people can feel different ways about the *same* thing, that feelings change, and that there are ways to find out—by listening, by watching, and by asking. Understanding that everyone does *not* choose what they like can lead to possible faulty conclusions in problem solving, and games are included that help children discover that *different* people may like different things. After about eight weeks, the time that pilot trials suggested the children are ready for the next series of lessons, the children are exposed to games and dialogues that teach the final problem-solving skills of considering solutions to problems and consequences to acts. With pictures, puppets, and role-plays, the teacher or the children identify a problem-solving situation—first fictitious problems, then real ones. The task requires that the prerequisite word pairs and feeling word concepts be incorporated, and children are asked questions such as:

1. What happened? What's the matter?

2. How is (each pictured child, puppet character, child actor) feeling?

3. What happened when (e.g., child 1 grabbed child 2's toy)?

4. What is a *different* way to solve this problem?

5. (After one child responds): That's one way. Now the idea of this game is to think of lots of *different* ways the child could have (gotten a chance to play with the toy). Who has way number 2?

After several lessons wherein children brainstorm as many alternative solutions as possible, with no value judgment placed on the content of the solutions, children are guided to evaluate for themselves whether a solution given *is* or *is not* a good one, and why. They are then asked:

6. Is that a good idea or not a good idea? What *might* happen next *if* (Child 1) does that?

The didactic lesson-games take about four months to complete, implemented daily for a period of 20- to 30-minutes.

In addition to the didactic lesson-games, teachers are trained to help children associate concepts practiced in hypothetical situations to problems that come up in real life. For example, a teacher asked Robert, who just hit Michael, "What's the problem?" "What's wrong?" Robert answered, "He's in my way!" The teacher then asked, "How do you think Michael feels when you hit him?" "Mad," answered Robert. "What happened when you hit Michael?" the teacher then asked. And Robert said, "He hit me back." Now the teacher asked a very important question, "How did *you* feel about that?" Still angry, Robert meekly replied, "Mad." Continuing the same line of questioning as in the hypothetical situations, the teacher followed with, "Can you think of a *different* way to get Michael to let you play with the toy?" Robert thought for a moment, a big step in itself, and said, "I could invite him to my birthday party."

Robert's response was important because his first impulse typically was to hit or push when frustrated. Instead of the teacher punishing this child, or doing the thinking for him by suggesting another way to get to play with the toy, or even suggesting why, Robert was helped to think of his own solutions that might have consequences that are more positive. We call this kind of guidance "ICPS dialoguing," because it engages children in a genuine two-way conversation that turns the child from a passive recipient to an active participant. With the help of ICPS dialoguing, Robert could begin to associate how he thinks with what he does and how he behaves. Instead of feeling anger and frustration, he felt pride.

Intermediate Grades

The overall style and approach to problem solving for intermediate-grade students is the same as that for younger children: to teach them how, not what, to think in solving interpersonal problems (Shure, 1992c). Although isolated games are not played with the ICPS word pairs, they are woven into the exercises to set the stage for the discussion of people's feelings, solutions, and consequences. New skills that the earlier described studies found to be related to behavior at this age (i.e., ability to read social cues, appreciating potential motives of other's acts, and sequenced, means-ends thinking) are also included.

During a thrice-weekly, four-month period, the concept that *there's more than one way* is stressed to develop a problem-solving thinking style. There is more than one way to: (a) explain another's behavior at a given moment (e.g., "Maybe he didn't wave at me because he doesn't like me," or "Maybe he just didn't see me."), (b) explain another's behavior that is consistent over time (e.g., "Maybe he bullies others because he thinks it's fun," "Maybe he's bullied at home," or "Maybe he thinks that's how he'll make friends."), and (c) to solve a problem. Children also learn that there is more than one way that others may react to what they do (i.e., potential consequences). Like the curricula for younger children, teachers are trained to apply ICPS dialogues when real problems arise.

ICPS for Parents

Because we were interested in learning whether parents could become effective training agents, we took ICPS into the home. We learned in our research that, before training, many mothers of African-American preschoolers were just as preoccupied with their own needs for their children ("You must learn to share your toys) as their children were with theirs ("But I did share, now I want it back!). Therefore, the goals for mothers were to: (a) increase their awareness that the child's point of view might differ from their own; (b) help them recognize that there is more than one way to solve a problem; (c) increase their understanding that *thinking* about what is happening may, in the long run, be more beneficial than immediate action to stop it, and (d) help them provide their children with a model of problem-solving thinking, that is, a thinking parent might inspire a child to think. Designed for use by parents of children ages four through six (Shure, 1996; Shure & Spivack, 1978), and now available in workbook form (Shure, 2000), the concepts are the same as those used by teachers of this age group, with the content of the problem situations being between peers at school, siblings, and between the parent and the child (e.g., child won't clean his room, go to bed on time). Parents are also helped to: (a) think about their own feelings and become sensitive to their child's feelings, (b) find out how their child viewed the problem, and (c) engage the child in the process of solving the problem through ICPS dialoguing. The next question is the extent of impact the teacher and parent training programs[1] have had on the thinking and behaviors of young children.

ICPS Intervention Research

Our initial research with low-income, urban African Americans, now supported by others in both low- and middle-income levels across ethnic groups (summarized in Denham & Almeida, 1987), is reported in detail in Shure (2001), and in Spivack and Shure (1982). The major findings from that research are summarized below.

Training Provided by Teachers: Preschool/Kindergarten

In one study (Shure & Spivack, 1982), low-income African-American four-year-olds were studied over a two-year period. In their nursery school year, 113 children (47 boys, 66 girls) were taught the ICPS method (called the training group), while 106 (50 boys, 56 girls) served as controls. In kindergarten, 69 trained youngsters were still available, 39 who received training in both the nursery and kindergarten years (15 boys, 24 girls), and 30 (12 boys, 18 girls) who received no further training (to test for durability). Of the 62 still-available controls, 35 (15 boys, 20 girls) were first trained in kindergarten and 27 (12 boys, 15 girls) constituted the never-trained controls. All four groups were initially comparable in age, gender, Binet-IQ (range, 70-147), ICPS skills, and teacher-rated behavioral characteristics. All results reported below were significant at least at the 0.05 level.

- Before preschool (in the fall), 36% of the children to be trained were rated as behaviorally *adjusted* (not impulsive or inhibited), as were 47% of the controls. Following the intervention in the spring, 71% of the trained youngsters were rated adjusted, compared with only 54% of the controls.

- Of the 44 trained children rated as *impulsive* prior to the intervention and 39 controls, 50% of the trained children became adjusted compared with only 31% of the controls.

- Of the 28 initially *inhibited* trained children and 17 controls, 75% became adjusted, compared with only 35% of the controls.

- At six-month follow-up, 71% of the 80 still-remaining children rated adjusted at the end of preschool remained adjusted, compared with 42% of the 65 comparable controls. One full year later, of 30 trained and 27 never-trained, 77% of the trained retained their adjusted behavior vs. only 30% of the controls.

- In addition, at six-month follow-up, 25 of 29 (86%) still-available children initially rated *adjusted* before ICPS training in the nursery year maintained that adjustment throughout the nursery year and at six-month follow-up, compared with only 18 of 31 (58%) of comparable controls. After one full year, at the end of kindergarten, eight of nine still-available youngsters initially rated adjusted maintained that adjustment compared with only 4 of 10 controls. These findings suggest a preventive as well as an intervention impact of ICPS training in the nursery year.

- Of the 35 initially *adjusted* children first trained in kindergarten and the 27 controls, 83% of those trained were adjusted following training, compared with only 30% of the controls. Of 20 trained youngsters initially showing either *impulsive* or *inhibited* behaviors and 16 controls, 79% were rated as adjusted in the spring (end of kindergarten), vs. only 6% of the controls.

That the same children who gained in ICPS skills also improved in measured overt behaviors suggests that the behavior gains were associated with gains in the trained ICPS skills. This finding, together with these linkages not having been explained by IQ or IQ change, supports Spivack's theory that ICPS skills do mediate behaviors, and that behavior can be modified by teaching children how to think about what they do, rather than by focusing directly on the behaviors themselves. Linkages were stronger for solution than for consequential thinking in both preschool and in kindergarten, but consequential thinking linked more strongly in the kindergarten year. Perhaps thinking simultaneously of what to do (now) and what might happen next (later) is developmentally more possible at age five than at age four. The percentage of children rated adjusted was greater in all trained groups, compared with control children. The results also suggest that, if training is not conducted in nursery school, kindergarten would not be too late. Importantly, the percentage of adjusted controls decreased by the end of the two-year period, suggesting that ICPS intervention can reverse that trend.

Training Provided by Teachers: Intermediate Grades

In both grades 5 and 6, 92 children (47 boys, 45 girls) were studied (Shure, 1984; Shure & Healey, 1993). The primary aims were to study the impact of ICPS training beginning at age 10 (in grade 5) as compared with ICPS training earlier in life (at ages 4 and 5), and to compare ICPS training with impersonal Piagetian Critical Thinking (CT) skills at that age. Children trained in grade 5 only or in grades 5 and 6 in either the ICPS or CT groups were comparable in behavioral adjustment and ICPS test scores before the interventions in grade 5. Major findings of Shure and Healey (1993) are as follows:

- With pretest scores, IQ, and academic ability controlled, ICPS-trained youngsters gained significantly more than CT-trained controls in the trained ICPS skills of alternative solutions, consequential thinking, and means-ends thinking (sequential planning skills), as measured at the end of grade 5. They maintained those gains through grade 6, especially the two-year trained ICPS group with regard to alternative solution and means-ends thinking skills.

- *Positive, prosocial* behaviors (e.g., liked by peers, cares, shares, concern for the feelings of others in distress) significantly improved in ICPS- vs. CT-trained youngsters whether rated by teachers, peers, or independent observers.

- *Impulsive* peer-rated behaviors such as aggression, overemotionality, and impatience decreased in the two-year ICPS- vs. CT-trained groups by the end of grade 6 in both sexes, more dramatically in girls.

- *Shy* peer-rated behaviors were significantly lower in ICPS- than CT-trained youngsters at the end of grade 6 for both boys and girls.

- Linkage analyses support the notion that ICPS skills, particularly solution skills, are significant mediators of behavior change, especially as rated by peers, and most powerfully for prosocial behaviors. That is, ICPS-trained youngsters who most improved in solution skills also most improved in the extent to which they were liked and sought out by peers, and showed concern for others in distress.

While it took only *one* three-month exposure (in either the nursery *or* kindergarten year) to decrease *negative* behaviors, and it took a *repeated* three-month exposure (in grades 5 *and* 6) to decrease those behaviors in older children, it is not too late for ICPS to have a beneficial impact on children's mental health and early high-risk behaviors at age 10 or 11. Standardized achievement test scores and reading grade book levels also improved, suggesting that less stress fostered by ICPS skills allows children to concentrate better on the task-oriented demands of the classroom and, subsequently, to do better in school.

Regarding the issue of stress and academic achievement, Elias et al. (1986) have shown that fifth-graders who learn problem-solving skills experience less stress during their transition from elementary to middle school. These stresses, in addition to the logistics of transferring to a new school and coping with peer pressure, include adjusting to more stringent academic requirements. The youngsters in the Elias et al. study stayed on task and did better in school. Similarly, Dubow and Tisak (1989) found those youngsters who are preoccupied with emotional stress (e.g., feeling left out by peers) have difficulty paying attention in school and, consequently, some difficulty learning. These authors found that problem-solving skills help children formulate strategies to cope with stressors from parents, teachers, and peers, which in turn helps them feel emotionally free to concentrate on their schoolwork.

Training Provided by Mothers: Preschool Children

Shure and Spivack (1978) studied 40 African-American mother-child pairs, 20 of whom received training and 20 of whom were nontrained controls. The children were comparable in mean age (4.3 years), school behavioral adjustment level, and gender (10 boys, 10 girls per group). To study the maximum impact of ICPS training by mothers on the behavior of their children, mothers of children displaying school behaviors classified as impulsive or inhibited were recruited. Training groups consisted of 3 initially adjusted youngsters, 13 impulsive, and 4 inhibited. Control groups contained 4, 12, and 4 children, respectively.

- 71% of the trained youngsters moved from an impulsive or inhibited behavioral classification to adjusted, compared with 31% of the controls.

- Gains in alternative solution skills linked more strongly with behavior gains than consequential skills—a finding similar to that in the four-year-olds trained by teachers.

- Mothers who improved their own problem-solving skills and applied ICPS dialogues (use of the problem-solving approach when handling real problems at home) had children who most improved in the trained ICPS skills and behaviors.

- The improved behavior of children trained at home generalized to the school, suggesting that the benefits of acquiring ICPS mediating skills are not situation-specific.

Teachers and Mothers as Trainers, Kindergarten/Grade 1: Five-Year Longitudinal Study

A study of children trained in kindergarten, or kindergarten and grade 1, and followed through grade 4 (Shure, 1993) was the culmination of 20 years of research to test the ICPS/behavioral mediating hypothesis. The primary aim was to address the long-term effectiveness of ICPS training on cognitive and behavioral outcomes of two amounts and two forms of program reinforcement (in school and at home). The sample was 542 inner-city, African-American, low-income kindergarten youngsters (264 boys, 278 girls). Of these, 120 boys and 132 girls remained throughout the five years of the study.

- Among the 200 boys and 180 girls remaining at the end of grade 1 (first program assessment), some youngsters were trained by their teachers in kindergarten and received no further training. Others were trained by their teachers in both kindergarten and grade 1, and still others by their teachers in kindergarten and their mother in grade 1. All three trained groups were, compared with a fourth group of never-trained controls, ahead in both solution and consequential skills, especially solution skills. They were also displaying more positive and fewer negative behaviors, especially those trained for two years by their teachers, and especially as rated by independent observers on the Achenbach and Edelbrock (1983) Direct Observation Form.

- In grade 2, mother-trained girls were the least impulsive, the least inhibited, and showed the fewest total behavior problems, especially as rated by independent observers, with the same being true for boys trained by teachers for one or both years.

- In grade 3, two-year teacher-trained boys were the least impulsive and showed the fewest total behavior problems. Importantly, however, mother-trained boys and girls who most improved in behaviors were those whose mothers best learned to apply the ICPS dialoguing approach, findings similar to those of the preschoolers trained at home.

- In grade 4, now three years after the final training, and with 120 boys and 132 girls still remaining, some dramatic "sleeper effects" emerged. That is, after some drop in measured effectiveness of ICPS training on behaviors in grades 2 and 3, there was a significant improvement by both sexes shown in grade 4. On all three factors rated by independent observers—external (*impulsivity*), internal (*inhibition*), and total problem scores—the two-year teacher-trained boys and girls emerged as dramatically superior. Again, in the mother-trained group, children whose mothers best applied the ICPS dialogues were still maintaining their significant gains at the end of grade 4.

ICPS Replications and Related Programs

One replication of the impact of the Shure (1992b) ICPS curriculum for schools was conducted by a group of school psychologists in the Miami-Dade County Public Schools (Aberson, Albury, Gutting, Mann, & Trushin, 1986). Subjects were 9 children from each of 12 kindergarten classrooms representing a variety of income and cultural groups within the Miami-Dade County school system. With students from 12 control schools, matched in the ICPS skill of alternative solution thinking and behavioral classification at pretest, each group contained three well-adjusted, three shy, and three acting-out children based on preratings on the Acting Out, Moodiness, and Learning Scale, or AML (Cowen et al. 1973) and the Behar Rating Scale (Behar & Stringfield, 1974). Additional ratings of prosocial attributes such as concern for others, initiative, and autonomy were included from a rating scale constructed by the authors.

Results indicated that the ICPS-trained children in all three behavior groups improved significantly in their ability to generate alternative solutions to interpersonal problems compared with controls. Acting-out children improved significantly relative to controls in reducing acting-out behaviors and hyperactivity, and in peer acceptance as rated by teachers. Inhibited children improved in initiative and autonomy, while it was the well-adjusted children who improved most in their observed concern for others. This finding is important in light of findings by Hastings, Zahn-Waxler, Robinson, Usher, and Bridges (2000), who found that youngsters who showed concern for others at ages 6 and 7 were less likely to show externalizing behavior problems, and those children, in turn, would show fewer such problems at ages 9 and 10. Perhaps those who most improved in their concern for others at age five in the Aberson et al. study would be least likely to show externalizing behavior problems later. It is also important to note that many of the Hispanic children in their study had to be pretested in Spanish on the PIPS test, but were able to provide significantly more solutions in

English after training. It may be that the strong language component of this program contributed to the children's progress in acquiring the English language.

There have been an escalating number of problem-solving prevention programs for relatively normal children with varying degrees of behavior problems. Some were direct replications of ICPS, such as that of Feis and Simons (1985). These researchers found that ICPS skills and behavior of low-income, rural preschoolers not only improved relative to controls, but also significantly fewer of them were referred to the mental health consultant. Others have developed their own programs for various age groups (see meta-analysis in Denham & Almeida, 1987). Still newer programs include well-researched ones by Carolyn Webster-Stratton, who, in a study of more than 800 children ages 3 to 7 referred for conduct problems, found improved parental attitudes and parent-child interactions, reduced parents' use of violent forms of discipline, and reduced child conduct problems. In addition, trained teachers, compared with non-trained controls, were less critical in their discipline approaches and more likely to involve parents in their classrooms (Webster-Stratton & Hammond, 1997).

Use of Interpersonal Cognitive Problem Solving With Special-Needs Children

With a sample of three middle-income mothers of children (two boys, one girl) with ADHD, Aberson (1996) used a single-subject design to test a modified version of Shure's ICPS program for families, called Raising a Thinking Child (Shure, 1996). Her goal was to improve executive functioning and social/emotional development. Using the Behavior Assessment System for Children (BASC) Rating Scale (Reynolds & Kamphaus, 1992), and the Home Problem Questionnaire-Revised (DuPaul & Barkley, 1992), ratings were collected before and after the six-week program, with follow-up six months and four years later. Aberson found that the intervention resulted in improved overall adjustment as measured by the BASC. In addition, as rated by teachers, parents, and the children themselves, improved interpersonal relationships occurred in all three subjects at postintervention, and at both six-month and four-year follow-up on the BASC and on the Home Problem Questionnaire. Behavior conduct grades also improved as rated by teachers (Aberson & Ardila, 2000). Aberson's (1996) research, combined with research that finds that ICPS-trained children's behavior does improve significantly more than controls (reviewed in Denham & Almeida, 1987; Spivack & Shure, 1982), supports the probable impact of ICPS parent training on the behavior of these youngsters. Importantly, Weiss and Hechtman (1993) found that, without intervention, hyperactive children continue to demonstrate discipline problems and poor peer relations in adolescence.

The Aberson studies included ICPS dialogues reported from teachers and from parents, which showed how adults helped children associate ICPS thinking with real life. Although the parent in the illustrated example (see Table 1, on page 122) might have added additional components (see notes in the table), it shows how even less than complete ICPS dialogues can influence children.

Table 1

Problem-Solving Dialogue Between Mother and Her Child

Eight-year-old boy with ADHD: Fighting with younger brother

Mother:	Do you think it is a good idea to push your brother?
Child:	No.
Mother:	What happened *before*[a] you pushed him?
Child:	I was trying to get the toy nicely and he refused. I tried to trade it for another toy, and he refused. When I tried to get the toy, he pushed me, and I pushed him back.
Mother:	What is a *different*[a] thing you could have done instead of trying to grab the toy or push him?[b,c]
Child:	Don't push him back and try to get the toy in another way like telling him he has 15 minutes to play with it. If that doesn't work, I'll ask you or dad to help.

Notes

For more ICPS dialogues, see Shure, M. B. (2000). *Raising a thinking child workbook.* Champaign, IL: Research Press. [a] *I Can Problem Solve (ICPS)* words taught in game form, applied to real-life dialogues. [b] Before asking this question, the mother could have asked: "How do you think your brother feels when you push him?" [c] Mother could substitute "instead of trying to grab ..." with "so your brother won't feel that way?"

The ADHD children themselves showed how newly acquired ICPS skills allow them to use internal language to help them problem solve and control their impulses. For example, Child A was often teased because he was fat. Before the intervention in second grade, he responded with verbal or physical aggression. He had no friends and was engaged in daily altercations with peers. Learning ICPS skills helped him in significant ways. Four years following training, in grade 6, this boy reported that sometimes he was still teased because he was fat. However, when peers occasionally called him "Bacon," he was able to control his tendency to lash back by thinking of a more adaptive solution to this problem. Using humor, he simply said, "Yes, and I sizzle." In grade 6, this youngster had many friends and his academic and conduct grades in school were "A"s and "B"s (Aberson & Ardila, 2000).

The female child, who initially argued with her mother about getting ready in the morning, commented at six-month follow-up that this was no longer a problem. She now thought to herself, "If I get up in time, I won't get in trouble and be late to school." This girl also had difficulty making friends and was unsuccessful in school, and would withdraw or cry when children teased her. Six months later, she replied that when teased, she would say, "Please stop. Let's just be friends and not fight."

The third child, like the second, had difficulty getting ready in the morning to the point that his mother helped him brush his teeth and dressed him. One morning he surprised his parents when he came into their bedroom dressed and ready for school before they were up. He told them that he wanted to have time to do his chores before going to school since he wanted to visit his grandparents that day after school, and might not get his chores done. This kind of planning ahead never occurred before. It may also be noted that this child, who was vulnerable to peer pressure initially, stated in his interview four years later that he decided that he did not have to be friends with everyone because "some friends can get you in trouble." Four years after the initial training, all three of these children were functioning well socially, emotionally, and academically in middle school.

Mark Greenberg and his colleagues have now also documented that problem-solving training can help children with various levels of behavioral difficulties. Greenberg, Kusche, Cook, and Quamma (1995) implemented their PATHS (Promoting Alternative Thinking Strategies) program with second- and third-grade students in regular education and first- to third-grade students in special education (with learning disabilities, mild mental retardation, severe behavioral disorders, or multiple handicaps). After training in feeling identification, empathy, and problem-solving skills, both groups improved in the quality of their social planning, regular students decreased in externalizing behaviors, and the special education students decreased in internalizing ones. Importantly, 18 months later, Greenberg and Kusche (1997) reported that both groups of students maintained gains in self-regulation, recognition of feelings, empathy, and conflict-resolution skills, and both groups were showing decreased externalizing behaviors. These findings, together with those of Aberson and Ardila (2000), of Shure and Spivack (1982), and of others cited in this chapter highlight the efficacy of emotion and problem-solving-based programs for children with and without special needs.

Models of Implementation

The lesson-games and exercises in the ICPS curricula for teachers and parents are self-explanatory. Some issues of implementation, however, need to be discussed with trainers or directly with the teachers and parents themselves.

In the Classroom

Although ICPS can be implemented in a variety of ways depending on the situation in a particular school, research has shown that more behavioral improvement is obtained when a teacher implements ICPS with the entire classroom (e.g., Shure & Spivack, 1982) than when selected high-risk students are removed from the classroom (e.g., Sharp, 1981). Children who are excluded could feel left out, and those who are included could feel special. Further, if only some children in the class receive training, only some children in the class will be able to respond to the ICPS dialoguing approach. Whether implemented with the whole class, or in small groups, the important factor is that the dialogues be communicated to children when conflicts come up in real life. In support of this notion, Weissberg et al. (1981) attribute greater increased behavioral impact of their problem-solving program in their later studies, at least in part, to more closely monitored training and consultation efforts, to an expanded curriculum, and to a more *systematic incorporation of dialoguing* during the day. In fact, Weissberg and Gesten (1982) noted that teachers of school-aged children report that dialoguing may be the key to independent problem-solving thought. Thus, it is ideal to share dialoguing techniques with other professionals and parents within the school.

Fitting ICPS Into the Classroom

For nursery and kindergarten teachers to find time to implement *ICPS* during the day without interfering with the academic schedule, we find that 30 minutes at story time is ideal for maximum group participation. For teachers who have the same children for the full day, it is ideal to work with smaller groups, by training half the class in the morning, the other half in the afternoon. In the intermediate grades, we find it possible to substitute the program with language arts for one 45-minute period every other day for a 4-month period. Because ICPS consists of stories and integration of the interpersonal concepts into literature as well as language arts, children do not lose language arts and, in fact, our research has found they do better on their standardized achievement test scores (Shure, 1993).

ICPS and the Role of the School Mental Health Professional

For any program to be successfully implemented in a school setting, there must be a built-in infrastructure to maintain it. It is not enough for outside trainers to come in, even train the teachers, and then expect teachers to independently conduct lessons on a systematic basis without some ongoing support from within. School mental health professionals are in a prime position to help in several ways. First, they can visit ICPS classrooms, ask how the lessons are going, and inquire whether there is anything they can do to help (perhaps use ICPS dialoguing with children in conflict). Second, they can train teachers and consult with them concerning dialoguing with difficult children and, on occasion, model dialoguing in the classroom or on the playground. Third, if possible, they can hold regular meetings with teachers, even if only once a month, to provide a forum for teachers to share their successes and failures and brainstorm with the group any questions or problems they may have. If such meetings are possible, it is helpful for teachers to document and share some of their dialogues with the group. In this regard, it is optimum for teachers of the same grade level to meet once a week to provide support for each other, preferably with the leadership of a school mental health professional.

By doing at least some of the ICPS lesson-games in the classroom, school mental health professionals can help teachers who initially feel too overwhelmed to add the lessons into their day's activities. These teachers can, however, learn to apply the dialogue techniques in real life. For example, instead of focusing attention on a child being out of his seat, a teacher can ask, "Is this a good time or *not* a good time to walk around the room?" If children are talking during a lesson, the teacher can ask, "Can you talk and listen to me at the *same* time?" If a child is playing with a toy during story time, the teacher can ask, "Is this a good time or *not* a good time to play with the toy?" and then, "Can you think of a *different* place to put the toy?" As a school psychologist, the first author used this model in a kindergarten classroom, and soon the teacher decided she wanted to do the lesson-games herself. Had she been pushed to do them at the start, she might never have done them at all. In addition, school mental health professionals who work with small groups of high-risk children can conduct the lesson-games outside of the classroom, as long as the classroom teacher is also trained at least in the real-life dialoguing techniques, and preferably the lesson-games as well. Any work with individual children can be supplemented with concrete exercises from the parent programs (Shure, 1996; 2000) because those programs are designed for use by one child at a time. Finally, any school mental health professional who works with after-school programs can provide consultation to the staff in ICPS lesson-games and dialogue techniques and, where possible, combine with parent training by having one after-school-care worker train a group of children while another works with parents.

ICPS With Parents

There are several possible ways to implement *Raising a Thinking Child* (Shure, 1996). Now in workbook form for children ages four to seven (Shure, 2000), the program provides a set of interactive exercises with pictures children can color, circle, or draw lines through, and exercises for the parents to help them move to the problem-solving level of communication.

One model is for a parent educator to meet with a small group of parents for about six weeks (after which most will ask for more time). Each week parents implement the games and exercises with their child(ren), and try problem-solving dialogues at home. Some trainers provide day care, and the children, in the next room, can be brought into a meeting one at a time to demonstrate a lesson. If weekly meetings are not feasible, teachers and/or the school mental health professional can duplicate strategic lesson-games so parents not only know what their children are learning, but also can try the exercises at home. To the extent that parents who teach ICPS skills to their children can help them prepare for school and help them learn, the Raising a Thinking Child program can complement the parent involvement initiative that is emerging in many schools nationwide.

The ICPS techniques have been used successfully by the first author in family therapy for children with ADHD and other special needs. She found it helpful to play some of the games with the whole family and then assign ICPS homework, preferably at a fixed time each day, or no less than once a week. Parents were asked to write at least one dialogue per week and bring it to the session. Parents reported that ICPS therapy helped to empower everyone in the family. They also reported that they felt less frustrated, began to enjoy their children more, and that older siblings began to "ICPS" with each other.

Conclusions

Some children, especially those more prone to violent solutions to problems, need assistance in coming up with nonviolent alternatives. It is imperative to teach these youngsters, who are more prone to precipitate crises, effective problem solving at an early age. A problem-solving program that incorporates empathy, and becomes a way of life, can be a powerful tool that can prevent children from experiencing feelings of anger and alienation and can give them the ability to use means of solving problems other than through violence or withdrawal—or giving up too soon. All individuals (whether they are parents, teachers, school psychologists, or other mental health professionals) who are involved in teaching problem solving play a pivotal role in helping children feel empowered. Then children realize they have choices and they have the skills to think about those choices when they must resolve problems or cope with adversity.

References

Aberson, B. (1996). *An intervention for improving executive functioning and social/emotional adjustment of ADHD children: Three single case design studies.* Unpublished doctoral dissertation, Miami Institute of Psychology.

Aberson, B., Albury, C., Gutting, S., Mann, F., & Trushin, B. (1986). *I can problem solve: A cognitive training program for kindergarten children.* Report to the Bureau of Education, Miami-Dade County Public Schools. Unpublished manuscript.

Aberson, B., & Ardila A. (2000). *An intervention for improving executive functioning and social/emotional adjustment of three ADHD children.* A four-year follow-up. Unpublished manuscript.

Achenbach. T. M., & Edelbrock, C. S. (1983). *Manual for Child Behavior Checklist and Revised Child Behavior Profile*. Burlington, VT: University of Vermont, Department of Child Psychiatry.

Barber, B. K. (1996). Parental psychological control: Revisiting a neglected construct. *Child Development*, *67*, 3296-3319.

Behar, L., & Stringfield, S. (1974). A behavior rating scale for the preschool child. *Developmental Psychology*, *10*, 601-610.

Cowen, E., Dorr, D., Clarfield, S., Kreling, B., McWilliams, S. A., Pokracki, F., Pratt, D. M., Terrell, D., & Wilson, A. (1973). The AML: A quick-screening device for early identification of school maladaptation. *American Journal of Community Psychology*, *1*, 12-35.

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information processing mechanisms in children's social adjustment. *Psychological Bulletin*, *115*, 74-101.

Denham, S. A., & Almeida, M. C. (1987). Children's social problem solving skills, behavioral adjustment, and interventions: A meta-analysis evaluating theory and practice. *Journal of Applied Developmental Psychology*, 8, 391-409.

Dodge, K. A., Pettit, G. S., McClaskey, C. L., & Brown, M. M. (1986). Social competence in children. *Monographs of the Society for Research in Child Development*, *51* (2, Serial No. 213).

Dubow, E. G., & Tisak, J. (1989). The relation between stressful life events and adjustment in elementary school children: The role of social support and social problem solving skills. *Child Development*, 60, 1412-1423.

DuPaul, G. J., & Barkley, R. A. (1992). Situational variability of attention problems. Psychometric properties of the revised home and school situations questionnaires. *Journal of Clinical Child Psychology*, *21*, 176-188.

Dwyer, K. P., Osher, D., & Warger, C. (1998). *Early warning timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education.

Elias, M. J., Gara, M., Ubriaco, M., Rothman, P. A., Clabby, J. F., & Schuyler, T. (1986). Impact of a preventive social problem solving intervention on children's coping with middle-school stressors. *American Journal of Community Psychology*, *14*, 259-276.

Feis, C. L., & Simons, C. (1985). Training preschool children in interpersonal cognitive problem-solving skills: A replication. *Prevention in Human Services*, *l4*, 59-70.

Greenberg, M. T., & Kusche, C. A. (1997, April). *Improving children's emotion regulation and social competence: The effects of the PATHS curriculum.* Paper presented at the biennial meeting of the Society for Research in Child Development, Washington, DC.

Greenberg, M. T., Kusche, C. A., Cook, E. T., & Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology, 7,* 117-136.

Hastings, P. D., Zahn-Waxler, C., Robinson, J., Usher, B., & Bridges, D. (2000). The development of concern for others in children with behavior problems. *Developmental Psychology, 36,* 531-546.

Hyman, I. (2000). Zero tolerance criticized. *The School Discipline Advisor,* p. 4. (Available from LRP Publications, 747 Dresher Road, Horsham, PA 19044).

Lee, M., Zimbardo, P. G., & Bertholf, M. (1977, November). Shy murderers. *Psychology Today,* pp. 69-70, 76, 148.

Nastasi, B. K., Varjas, K., & Bernstein, R. (1998). *Exemplary mental health programs: School psychologists as mental health service providers* (2nd ed., pp. 137-139). Bethesda, MD: National Association of School Psychologists.

Parker, J. G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low-accepted children "at risk?" *Psychological Bulletin, 102,* 357-389.

Raine, A., Brennan, P., & Mednick, S. A. (1997). Interaction between birth complications and early maternal rejection in predisposing individuals to adult violence: Specificity to serious, early-onset violence. *American Journal of Psychiatry, 154,* 1265-1271.

Raine, A., & Dunkin, J. J. (1990). The genetic and psychophysiological basis of antisocial behavior. Implications for counseling and therapy. *Journal of Counseling and Development, 68,* 637-644.

Reynolds, C. R., & Kamphaus, R. W. (1992). *Behavior Assessment System for Children (BASC).* Circle Pines, MI: American Guidance Service.

Roff. J. D. (1984). Childhood aggression and social adjustment as antecedents of delinquency. *Journal of Abnormal Child Psychology, 12,* 111-126.

Rubin, K. H. (1985). Socially withdrawn children: An "at risk" population? In B. H. Schneider, K. H. Rubin, & J. E. Ledingham (Eds.), *Children's peer relations: Issues in assessment and intervention* (pp. 125-139). New York: Springer.

Sharp, K. C. (1981). Impact of interpersonal problem-solving training on preschoolers' social competency. *Journal of Applied Developmental Psychology, 2,* 129-143.

Shure, M. B. (1982). Interpersonal problem solving: A cog in the wheel of social cognition. In F. C. Serafica (Ed.), *Social cognitive development in context* (pp. 133-166). Washington, DC: Guilford Press.

Shure, M. B. (1984). *Problem solving and mental health of 10- to 12-year-olds* (Report No. MH-35989). Washington, DC: National Institute of Mental Health.

Shure, M. B. (1990). *What happens next game (WHNG,* 2nd ed.). Philadelphia: Hahnemann University, Department of Mental Health Sciences.

Shure, M. B. (1992a). *I can problem solve (ICPS): An interpersonal cognitive problem solving program* [preschool]. Champaign, IL: Research Press.

Shure, M. B. (1992b). *I can problem solve (ICPS): An interpersonal cognitive problem solving program* [kindergarten/primary grades]. Champaign, IL: Research Press.

Shure, M. B. (1992c). *I can problem solve (ICPS): An interpersonal cognitive problem solving program* [intermediate elementary grades]. Champaign, IL: Research Press.

Shure, M. B. (1992d). *Preschool interpersonal problem solving (PIPS) Test* (2nd ed.). Philadelphia: Hahnemann University, Department of Mental Health Sciences.

Shure, M. B. (1993). *Interpersonal problem solving and prevention. A comprehensive report of research and training: A five-year longitudinal study* (Report No. MH-40801). Washington, DC: National Institute of Mental Health.

Shure, M. B. (1996). *Raising a thinking child.* New York: Pocket Books.

Shure, M. B. (2000). *Raising a thinking child workbook.* Champaign, IL: Research Press.

Shure, M. B. (2001). How to think, not what to think: A problem-solving approach to prevention of early high-risk behaviors. In A. Bohart, & D. Stipek (Eds.), *Constructive and destructive behavior: Implications for family, school, and society* (pp. 271-290). Washington, DC: American Psychological Association.

Shure, M. B., & Healey, K. N. (1993, August). *Interpersonal problem solving and prevention in urban school children.* Paper presented at the meeting of the American Psychological Association, Toronto, Canada.

Shure, M. B., & Spivack, G. (1972). Means-ends thinking, adjustment and social class among elementary school-aged children. *Journal of Consulting and Clinical Psychology, 38,* 348-353.

Shure, M. B., & Spivack, G. (1978). *Problem solving techniques in childrearing.* San Francisco: Jossey-Bass.

Shure, M. B., & Spivack, G. (1982). Interpersonal problem solving in young children: A cognitive approach to prevention. *American Journal of Community Psychology, 10,* 341-356.

Spivack, G., Platt, J. J., & Shure, M. B. (1976). *The problem solving approach to adjustment.* San Francisco: Jossey-Bass.

Spivack, G., & Shure, M. B. (1974). *Social adjustment of young children.* San Francisco: Jossey-Bass.

Spivack, G., & Shure, M. B. (1982). Interpersonal cognitive problem solving and clinical theory. In B. Lahey & A. E. Kazdin (Eds.), *Advances in child clinical psychology* (Vol. 5, pp. 323-372). New York: Plenum.

Straus, M. B. (1991). Discipline and deviance: Physical punishment of children and violence and other crime in adulthood. *Social Problems, 38,* 133-152.

Vygotsky, L. S. (1962). *Thought and language.* New York: MIT Press.

Webster-Stratton, C. & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65,* 93-109.

Webster-Stratton, C., & Hammond. M. (1998). Conduct problems and level of social competence in Head Start children: Prevalence, pervasiveness and associated risk factors. *Clinical Child Psychology and Family Psychology Review, 1,* 101-124.

Weiss, G., & Hechtman, L. (1993). *Hyperactive children grown up.* New York: Guilford Press.

Weissberg, R. P., & Gesten, E. (1982). Considerations for developing effective school-based social problem-solving (SPS) training programs. *School Psychology Review, 11*, 56-63.

Weissberg, R. P., Gesten, E. L., Carnrike, C. L., Toro, P. A., Rapkin, B. D., Davidson, E., & Cowen, E. (1981). Social problem-solving skills training: A competence-building intervention with second- to fourth-grade children. *American Journal of Community Psychology*, 9, 411-423.

Endnote

[1] *I Can Problem Solve* (for schools) and *Raising A Thinking Child* (for families) were recognized by the National Association of School Psychologists as exemplary mental health programs (Nastasi, Varjas, & Bernstein, 1998).

危
機

7

The Prevention of School Violence

Michael J. Furlong, Ph.D.
Renee Pavelski, M.Ed.
Jill Saxton, M.Ed.
University of California, Santa Barbara

School violence includes a range of experiences from teasing, taunting, harassment, physical intimidation, and even assaults. In its most extreme forms school violence manifested itself as tragic school shootings that resulted in multiple deaths during the 1990s (Furlong, Kingery, & Bates, 2001). In all its forms, but particularly in shooting incidents, school violence creates crises for schools. It is imperative that school personnel be prepared to mobilize resources in response to violence on school campuses. The purpose of this chapter is to encourage school practitioners to implement prevention programs to reduce violence at schools as a central component of crisis prevention. In our view, efforts to prevent school-site violence have reached the stage where it is now inexcusable to pick a program off the shelf, implement it, and claim that a viable violence-prevention program is in place. Furthermore, the distinction between what is prevention and intervention is blurred as programs are implemented with younger and younger children. Despite the need to pursue prevention, these efforts have been hindered because programs were previously organized in categorical ways that did not encourage strategic thinking about school-site violence prevention. In the discussion that follows, we present information about exemplary prevention programs embedded within a model for thinking strategically about violence prevention. This presentation focuses on how to organize prevention efforts that reaffirm, reconnect, reconstruct, repair, and protect relationships with students at school. It is not possible to extensively review school violence-prevention programs in this chapter because of space considerations; however, we do not think such a review is necessary or even desirable. School crisis response teams need to be informed about the range of viable programs but, more importantly, they need a way to think strategically about violence-prevention and intervention programs—programs that are selected because they appropriately address the concerns and needs of specific schools.

Strategic School Violence Prevention

Our strongest recommendation is that school violence-prevention programs should not be pulled off the shelf and implemented without first documenting school-site needs. These needs should be included as objectives of a school's violence-prevention efforts. As part of the process of prevention planning, school crisis response teams need to address fundamental questions, such as:

1. Which problems are we likely to face at OUR school?
2. Which theories are motivating program implementation, i.e., what knowledge base is used to help understand the origins and causes of school-site violence?
3. What are the primary short-term and long-term objectives of OUR school violence-prevention efforts?
4. Who are the targets of the violence-prevention efforts?
5. Are these prevention efforts organized primarily at the school or district levels?
6. How are the prevention efforts linked to broader, community-level violence initiatives?
7. Five years from now, how will the school know if these violence-prevention efforts worked?

Thinking Strategically About School Violence Prevention

In addressing these fundamental questions, it is necessary for schools to select violence-prevention programs and materials only after considering their match to the school's prevention objectives. Fortunately, there are a number of high-quality sources of information about programs that have promising characteristics and that have the potential to help schools implement meaningful violence-prevention programs (e.g., California Department of Education, 1998; Canter 2000; Drug Strategies, 1998; Hamilton Fish National Institute on School and Community Violence Center, 2000; and the National Center for Safe Schools, 2000). These sources provide current information about the most promising violence-prevention programs and resources.

Although there are a number of excellent sources of information about violence prevention, it can be difficult to know which specific program holds the most promise for addressing the needs of a specific school. One reason for this difficulty is that categorization of programs is hampered because they were typically created without reference to a coherent model accounting for factors associated with school violence. Many programs span age ranges and attempt to influence one or more domains of school violence. Thus, in reviews such as this one, it is difficult to organize prevention programs because they do not easily fit into prespecified categories.

Powell et al. (1996) presented information about 15 general youth violence-prevention projects that were funded by the Centers for Disease Control. They organized these model programs by the "level of intervention strategy," which included the individual level (e.g., social skills training), proximal interpersonal system (family counseling, preventing association with antisocial peers), proximal social settings (e.g., changing teaching practices, changing school climate), and societal macrosystems (e.g., job training and placement). Such an organizational structure may have relevance for community-level youth violence-prevention programs, but has limited guidance potential for school crisis response teams.

Another approach to categorizing prevention programs is offered in *Safeguarding our Children: An Action Guide* (Dwyer & Osher, 2000), developed to accompany *Early Warning, Timely Response* (Dwyer, Osher, & Warger, 1998). The *Action Guide* organizes programs under one of three major categories: (a) universal prevention (programs for all students), (b) early intervention (for high-risk students), and (c) intensive intervention (for students who have already aggressed repeatedly against others). Recognizing the potpourri of components that are often included in each program package, the *Action Guide* notes, "Some of these programs have multiple foci and therefore are listed under more than one category" (p. 55). The *Action Guide* also suggests that it is possible to evaluate program content for its adaptability to classroom-level implementation.

In another context, Morrison, Furlong, and Morrison (1997) suggested that school violence-prevention efforts be organized by taking into consideration the differing developmental needs of students. Most students never seriously aggress at school, but they may still benefit from a "one for all" or universal program that enhances their prosocial problem-solving skills. Such programs, however, are not well suited to address the more complex needs of the victims or perpetrators of violence at school. More recently, Canter (2000) edited a special report for the National Association of School Psychologists that described promising prevention programs by functional domains in schools; for example, by disciplinary practices, classroom behavior management, special education manifestation evaluations, conflict resolution, anger management, and so on.

Strategically Selecting School Violence-Prevention Resources

When it comes to the prevention of school violence and the crises that it spawns, traditional models often refer to primary prevention, secondary prevention, and tertiary prevention. In our way of thinking, these terms have meaning only when used in the context of which specific behaviors or classes of behaviors they are intended to prevent. Fights at school? Weapon possession at school? Bullying behavior? What is supposed to be prevented? After the murders at Columbine High School in April 1998, there was widespread concern among policy makers, who wanted to take steps to prevent school violence. While this was an entirely justifiable and understandable response, the question still remains: What specifically should these programs prevent? Because of these considerations, it is important that school crisis response procedures be integrated into broader school safety and violence-prevention efforts.

There is a continuum of harm that can happen to students that is associated with aggressive behavior at school. If the entire range of violence is included, then the demarcation of what is prevention and what is intervention becomes blurred. Programs designed to reduce fights on the schoolyard could be classified as an intervention program for those youths who have a clear past history of fighting in school. A history of aggressive behavior also is one marker of risk for more extreme forms of violence (Dwyer et al., 1998). Therefore, such programs can be considered prevention programs when the outcome of shootings is considered. We mention this because regardless of the term used to classify overall program strategies, the bottom line is that school personnel need to consider levels of intervention and proximal outcomes when thinking about how programs fit into their prevention-intervention framework. Generic violence-prevention programs can be useful, but if school or community individuals are focused on the prevention of rare multiple homicides when they discuss the need for violence prevention, then misunderstandings can occur. Consensus about desired outcomes is needed at the beginning of the process of developing a school violence-prevention program. As we discuss later, many violence-prevention programs do not target such events specifically, but attempt to reduce their occurrence by derailing youths who are on pathways toward serious violence. When organizing school violence-prevention efforts, it is necessary to carefully evaluate the levels and domains of program implementation and link these to desired outcomes. Without clarity at an early stage, there may be a mismatch between program content and desired outcomes. Before selecting entire prepackaged programs or subcomponents of promising violence-prevention programs and resources, a crisis response team should at a minimum consider issues related to the desired targets and domains of prevention efforts.

Targets of school violence prevention. Prevention efforts begin at the point of identifying which students or other individuals will participate in the prevention program. This is a critical decision because all discussion and program selection decisions will flow from the needs of those individuals whose behavior and attitudes will be the target of prevention efforts. School violence-prevention personnel will need to ask: Who are the primary recipients of the prevention program? Whose behavior is expected to change in the short term and the long term?

As a unifying theme for selecting the level of prevention activities, we use the concept of supportive connections or interpersonal bonding. Following from the works of risk and resiliency researchers, it has been found that students who report having positive supportive connections with school staff have more positive developmental outcome than students without such connections (Resnick et al., 1997). One way to think about levels of violence prevention is to consider how these activities influence student bonding at school. For most students who are reasonably well bonded to school, the primary task is to *Reaffirm* relationships with them. Many school violence-prevention programs, such as the Second Step program (Committee for Children, 1997), seek to strengthen bonds with students who are already meaningfully engaged in the schooling process.

Other students' social connections at school are more estranged, and prevention efforts should reach out to *Reconnect* with them. These youths are still peripherally involved in school, but are at risk of increasing involvement in aggressive and disruptive behavior. They have not traversed far down a developmental pathway that leads to chronic aggressive behavior, so it may yet be possible to rescue these youths and reconnect with them interpersonally. As a rule of thumb, school personnel can monitor their student population and pay special attention to any student who requires involvement with a second public serving agency (probation, mental health, alcohol and drug, or child welfare). These youths' life contexts suggest the need for cross-agency case management. Efforts to prevent the involvement of these youths as victims, perpetrators, or both, of violence will require purposeful collaboration between the school and the community. Life Skills Training (Botvin, Mihalic, & Grotpeter, 1998) and First Step (Walker, Horner, Sugai, & Bullis, 1996) are examples of such programs. Schools should continue to work with these challenging students and seek to create preventive structures and services that increase the chances of maintaining these youths in their school of residence.

A third, smaller group of students has had such disrupted school and life experiences that they have no positive social bonds at school, thus making it necessary to *Reconstruct* relationships with them. These youths, often males, are those who Gabarino (1999) calls "Lost Boys." They have disengaged academically and socially from school and are likely to have clear histories of aggression and other antisocial behaviors. A primary prevention effort with these youths is to connect them with a caring adult before they drift out of the influence of school and other community agencies. These youths require intensive services such as those included in Multisystemic Therapy (Henggeler, Mihalic, Rone, Thomas, & Timmons-Mitchell, 1998) and various Systems of Care programs (Stroul & Friedman, 1996).

A fourth, largely ignored, group of students are those who experienced aggression and other forms of victimization at school. For these youths the prevention task is to *Repair* their violated social bonds within the school community. These programs are important because of research showing an association between violence victimization and increased risk of future aggression by the victim (Dwyer et al., 1998). Examples of exemplary prevention programs that support victims of violence are found among school bully prevention literature (Hoover, Oliver, & Hazler, 1992). Currently, Pynoos (2000) is piloting a school-based program that screens for and serves youths who have been traumatized by violence victimization.

A fifth level of intervention addresses acts of school violence by nonschool individuals. In 1996, for example, Kathyrn Tran, age 15, was shot and killed on a high school campus in Los Angeles prior to her first period class by an older (aged 21) boyfriend. Other schools have experienced shootings when estranged husbands shot wives as they picked up their children from school or when gang members were involved in drive-by shootings. The prevention task for schools in such circumstances is to consider how they can take steps to *Protect* the relationship they have with their students. Efforts that target this level of violence prevention will often include security procedures designed to minimize threats of external harm to pupils. If a school crisis response team takes a triage approach to school violence prevention, the first task is to "secure the perimeter," by limiting external threats to ensure the security of students and staff.

Domains of school violence prevention. In addition to specifying primary prevention levels, we argue that school violence-prevention frameworks should be based on common domains of program content that are considered to have the greatest potential impact. Once the desired targets of intervention are selected, it will be helpful to address these questions: What domain of intervention is thought to be necessary to reduce the risk of violence at the school? Should multiple domains be addressed?

Depending on the interests and needs of each school, it is possible to conceptualize school violence-prevention efforts within at least eight domains or activities, which include (a) security, (b) screening and assessment of aggressive behavior, (c) relationship building and bonding, (d) individual student skill development, (e) developing nonviolent campus norms, (f) schooling process and structure, (g) school discipline and positive support, and (h) enhancing school climate. Crossing prevention targets by prevention domains produces a conceptual map of school violence-prevention activities that can be used for strategic planning, as shown in Table 1. Although most violence-prevention programs do not fit neatly into this structure, it does provide a useful heuristic with which to evaluate program purposes and content.

Table 1

Targets and Domains of School Violence Prevention Matrix (illustrative examples)

Primary Task of School Violence-Prevention Efforts: Targets of Prevention Effort					
Domains of Prevention Effort	**Reaffirm Relationships** [with the vast majority of students who are not at risk of serious violent behavior]	**Reconnect Relationships** [with students marginally involved in school & unresponsive to universal prevention programs]	**Reconstruct Relationships** [with students who already show signs of serious emotional & behavioral conditions that include aggressive behavior]	**Repair Relationships** [with students who are victims of serious and/or chronic verbal or physical attacks in school]	**Protect Relationships** [with students vulnerable to community violence intruding on campus]
Security	• School Uniforms • Staff Supervision	• Metal Detectors • Security Cameras & Monitors	• Probation-School Collaboration	• Adult Supervision for Bully Behavior	• School Resource Officers • Staff ID Badges
Screening and Assessment of Aggressive Behavior	• ESP • California Healthy Kids Survey	• Early Warning Signs Guidelines • First Step to Success			• School-Probation Communication about Violent Juvenile Offenders

BEST COPY AVAILABLE

	Primary Task of School Violence-Prevention Efforts: Targets of Prevention Effort				
Domains of Prevention Effort	**Reaffirm Relationships** [with the vast majority of students who are not at risk of serious violent behavior]	**Reconnect Relationships** [with students marginally involved in school & unresponsive to universal prevention programs]	**Reconstruct Relationships** [with students who already show signs of serious emotional & behavioral conditions that include aggressive behavior]	**Repair Relationships** [with students who are victims of serious and/or chronic verbal or physical attacks in school]	**Protect Relationships** [with students vulnerable to community violence intruding on campus]
Relationship Building and Bonding	• School Size • School Families	• Families & Schools Together • Gang Risk Intervention Program	• Multi-Systemic Therapy • Functional Family Therapy		
Individual Student Skill Development Social & Emotional Skills Development and Enhancement of Protective Factors	• I Can Problem Solve • Second Step	• BrainPower • The Anger Coping Program • The Coping Power Program	• Midwestern Prevention Project	• Positive Adolescent Choices Training	
Nonviolent Campus Norms	• Conflict-Peer Mediation Programs	• The School Safety Program • GRASP		• Bullying Programs • Dating Violence Prevention Program	
Schooling Process and Structure	• Cooperative Learning • Good Behavior Game	• Project ACHIEVE • Contingencies for Learning Academic & Social Skills	• Alternative School Options		
School Discipline and Positive Support	• BASIS • Constructive Discipline Model	• Behavioral Consultation Team • Zero Tolerance	• Manifestation Evaluations		
Enhancing School Climate	• Enhanced Extra-Curricular Activities • Campus Beautification	• Afterschool Programs & Activities	• School Probation Officers		

Note
Refer to the Appendix for information and availability of these prevention programs.

BEST COPY AVAILABLE

In addition to considering prevention domains when developing a school violence-prevention program, it is also desirable to consider the primary mode of delivery (classroom, media campaigns, family focus, consultation, etc.) and which individuals would implement the program (classroom teachers, counselors, psychologists, social workers), community agencies (public or private), peer advocates and so on. We further argue that differences in programs at this level represent local preferences for implementing school violence-prevention programs and should draw upon local resources. At a given school, the teaching staff may have the talent and energy to implement a schoolwide social-emotional curriculum and monitor its impact on playground fights and other aggressive behaviors. At yet another school, a counselor or psychologist may have special skills in anger management programs and thus could implement a counseling program with high-risk youths in conjunction with a classroom consultation component. In either case, regardless of the specific preferred implementation mechanisms, all school violence-prevention programs should consider the primary domains that will be addressed and which targets of intervention are most optimal at a given time. Thus, for example, a school that has a very high level of community violence and risk factors (e.g., availability of drugs and guns, excessively transient population, community disorganization, and poverty) may want to select interventions that first control the school's exposure to community conditions that bring violence to campus. Other schools will have different needs and agendas, and even the school that is focusing on the influence of community disorganization will not want to remain stuck at that level of intervention.

Conclusion

Schools have a unique opportunity to reduce the incidence of violence within American society. At one level, efforts to reduce school violence encourage the development of peaceful norms on the school campus, and they expand and strengthen student personal connections with adults, which may produce a generalizing effect to the broader community. In addition, schools provide the only viable setting in which to implement community antiviolence programs and to identify high-risk youths for intensive early intervention programs. Schools have an obligation to make campuses safe, secure, and peaceful and to collaborate with the broader community to address societal systemic violence (e.g., chronic/violent offenders, family violence, dating-relationship violence, hate-associated violence, and so on) and the crises that it causes. This perspective acknowledges that youth violence is a manifestation of broader social influences in American society. These broader socialization influences (e.g., coercive family processes, media exposure to violence, social norms that support the use of aggression as a problem-solving mechanism) increase the occurrence of violence on school campuses. We argue, however, that dynamics of the school environment itself either allow these influences to infect the school setting or inhibit their expression. Schools can create environments that enhance their ability to remain immune to these broader social influences of violence. In addition, educators can recognize that, as a major influence on America's youths, schools themselves can significantly alter socialization processes. This is possible by systematically including social-emotional curricula that purposefully expose students to activities designed to encourage them to learn about violence, to become aware of social messages regarding violence, and to practice prosocial problem solving behaviors. To engage in these violence-prevention efforts, educators need to evaluate and implement activities that complement school-site needs. As a resource to school-site prevention planning teams, we have included in this chapter's Appendix a listing of promising programs and resources, their availability, and have cross listed them by their primary targets and domain areas of school violence-prevention activities.

Fortunately, most schools are not overwhelmed by the dangers created by community risk factors or the behavior of lost boys or girls who are alienated from school and who have given up hope. For these schools, and eventually for all schools, the bulk of the school violence-prevention efforts will focus on broader, universal programs that seek to enhance students' social- emotional skills, improve the social and learning climate of the school, and encourage students' appreciation of nonviolent norms. These efforts hold promise for changing social norms about the use of violence as a problem-solving tool and for making school a better place to learn. Finally, it is now recognized that an effective way to reduce school violence and related juvenile offending is to begin prevention efforts as early as possible (Howell, 1995). We believe that the use of strategic school violence-prevention planning is a step in the right direction.

References

Botvin, G. J., Mihalic, S. F., & Grotpeter, J. K. (Eds.). (1998). *Life Skills Training*. Boulder, CO: University of Colorado, Center for the Study and Prevention of Violence.

California Department of Education. (1998). *Getting results: Developing safe and healthy kids*. Sacramento, CA: Author.

Canter, A. (2000). *Behavioral interventions: Creating a safe environment in our schools*. Washington, DC: The National Mental Health and Education Center, National Association of School Psychologists.

Committee for Children. (1997). *Second Step Program*. Seattle, WA: Author.

Drug Strategies. (1998). *Safe schools, safe students: A guide to violence prevention strategies*. Washington, DC: Author.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education. Available Online: www.air-dc.org/cecp/guide/annotated.htm

Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide*. Washington, DC: U.S. Department of Education. Available Online: www.air.org/cecp/guide/actionguide/Action_Guide.htm

Furlong, M. J., Kingery, P. M., & Bates, M. P. (2001). Introduction to the special issue on the appraisal and prediction of school violence. *Psychology in the Schools*. *38*, 89-106.

Garbarino, J. (1999, April). Lost boys: Why our sons turn violent and how we can save them. *Children's Services*. pp. 1-4.

Hamilton Fish National Institute on School and Community Violence Center. (2000). Hamilton Fish Institute website. Available Online: www.hamfish.org

Henggeler, S. W., Mihalic, S. F., Rone, L., Thomas, C., & Timmons-Mitchell, J. (Eds.). (1998). *Multisystemic Therapy*. Boulder, CO: University of Colorado, Center for the Study and Prevention of Violence.

Hoover, J. H., Oliver, R., & Hazler, R. J. (1992). Bullying: Perceptions of adolescent victims in midwestern USA. *School Psychology International*, *13*, 5-16.

Howell, J. C. (1995). *Guide for implementing the comprehensive strategy for serious, violent, and chronic juvenile offenders*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Morrison, G. M., Furlong, M. J., & Morrison, R. L. (1997). The safe school: Moving beyond crime prevention to school empowerment. In A. P. Goldstein & J. C. Conoley (Eds.), *School violence intervention: A practical handbook* (pp. 236-264). New York: Guilford Press.

National Center for Safe Schools. (2000). The safetyzone web page. Available Online: www.safetyzone.com.

Powell, K. E., Dahlberg, L. L., Friday, J., Mercy, J. A., Thorton, T., & Crawford, S. (1996). Prevention of youth violence: Rationale and characteristics of 15 evaluation projects. *American Journal of Preventive Medicine*, *12*, 3-12.

Pynoos, R. (2000). *Child Trauma Reduction Program*. Unpublished manuscript, University of California Los Angeles.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., Tabor, J., Beuhring, T., Sieving, R. E., Shew, M., Ireland, M., Bearinger, L. H., & Udry, J. R. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278*, 823-832.

Stroul, B. A., & Friedman, R. M. (1996). *A system of care for children and adolescents with severe emotional disturbance*. Washington, DC: National Technical Assistance Center for Child Mental Health, Georgetown University Child Development Center.

Walker, H. M., Horner, R. H., Sugai, G., & Bullis, M. (1996). Integrated approaches to preventing antisocial behavior patterns among school-age children and youth. *Journal of Emotional & Behavioral Disorders*, 4, 194-209.

Appendix

Promising School Violence Primary Prevention Programs

Program Name	Description	Contact Information	Target	Domain
Early Mental Health Initiative	State matching grant program for local educational agencies for students in grades K-3	Robin Mandella CA Department of Mental Health 1600 9th Street, #100 Sacramento. CA 95814 (916) 654-2131 *rmandell@dmhgw.cahwnet.gov*	Universal	Relationship Building and Bonding
Mental Health Services for High School Students	Provision of mental health services	Deloris Garrett IPS-Broad Ripple High School 1115 Broad Ripple Ave Indianapolis, IN 46220 (317) 226-2099	Universal	Relationship Building and Bonding
Palatine High School Wellness Program	Faculty and staff as members of a wellness team to benefit high school students	Robert Ingraham, Psy. D. Palatine High School 1111 N. Rohlwing Rd. Palatine, IL 60067 (847) 755-1600	Universal	Relationship Building and Bonding
Parents as Teachers	Multifaceted parent education for preschool children ages 0-5 and their families	Kricket Harden, Jenks Public School 205 E.B. St Jenks, OK 74037 (918) 299-4411	Universal	Relationship Building and Bonding
Primary Mental Health Project	Provision of mental health services to children pre-kindergarten to 3rd grade	A. Hightower & Deborah Johnson Primary Mental Health Project 575 Mount Hope Ave. Rochester, NY 14620 (716) 273-5957	Universal	Relationship Building and Bonding
School-Based Mental Health Initiative:Kids in Community Schools	Multifaceted onsite mental health program for pre-school and elementary school students	Megan Glynn School-Based Mental Health Initiative 135 Locust Hill Yonkers. NY 10701 (914) 376-5124	Universal	Relationship Building and Bonding
First Step to Success	A demonstrated program with proactive screening of all kindergarten students to reduce aggression and maladaptive behavior	Sopris West 4093 Specialty Place Longmont, CO 80504 (800) 547-6747	Universal	Screening and Assessment of Aggressive Behavior

Program Name	Description	Contact Information	Target	Domain
Aggressors, Victims, and Bystanders: Thinking and Acting to Prevent Violence	Utilizes the "Think-First Model of Conflict Resolution"	Chris Blaber Education Development Center, Inc. 55 Chapel St., Suite 25 Newton, MA 02458 (617) 969-7100	Universal	Individual Student Skill Development
I Can Problem Solve: An Interpersonal Cognitive Problem Solving Program	Teaches thinking processes that help resolve interpersonal problems	Myrna Shure MCP Hahnemann University Broad and Vine, MS 626 Philadelphia, PA 19102 (215) 762-7205	Universal	Individual Student Skill Development
Peace Builders	For grades K-5; designed to increase availability of pro-social models to decrease aggressive behaviors	Jane Guilibon, Heartsprings, Inc. P.O. Box 12158 Tucson, AZ 85732 (800) 368-9356	Universal	Individual Student Skill Development
Positive Education Program Early Intervention Center	Parents are taught to help children develop social skills and cognitive problem-solving skills	Laurie Albright Positive Education Program 5443 Rae Rd. Lyndhurst, OH 44124 (440) 461-0079	Universal	Individual Student Skill Development
Responding in Peaceful and Positive Ways	Students learn steps in avoiding, ignoring, defusing, and resolving conflicts	Aleta Lynn Meyer, Life Skills Center Virginia Commonwealth University 800 West Franklin, P.O. Box 842018 Richmond, VA 23284-2018 (888) 572-1572/ Fax (804) 828-0239	Universal	Individual Student Skill Development
Second Step	Designed to decrease physical aggression for pre-K through middle schools	Committee for Children 2203 Airport Way South, Suite 500 Seattle, WA 98134 *or* 172 20th Ave. Seattle, WA 98122 (800) 634-4449/ Fax (206) 343-1445	Universal	Individual Student Skill Development

BEST COPY AVAILABLE

Appendix continued p. 144

Appendix continued

Program Name	Description	Contact Information	Target	Domain
Social Decision Making and Problem Solving Program	Teaches students social competence skills in grades K-12	Maurice Elias, Rutgers University Livingston Campus New Brunswick, NY 08903 (732) 445-2444	Universal	Individual Student Skill Development
Social Skills Inclusion Model	Teaches social skills to elementary school children	Judy Kennedy Rapid City Schools 21 St. Joseph St. Rapid City, SD 57701 (605) 394-4036	Universal	Individual Student Skill Development
Violence Prevention Program	Teaches skills in problem solving, anger management, and alternatives to potentially violent situations	Violence Prevention Program Milwaukee Public Schools 8135 W. Florist Ave. Milwaukee, WI 53218 (414) 535-6665	Universal	Individual Student Skill Development
Peer Mediation	Students receive peer mediation training, preparing them to serve as peer mediators	Research Press 2612 N. Mattis Ave. Champaign, IL 61821 (800) 519-2707	Universal	Non-Violent Campus Norms
Resolving Conflicts Creatively Program (RCCP)	Teaches concepts and skills in conflict resolution and intergroup relations	RCCP National Center 40 Exchange Place, Suite 1111 New York, NY 10005 (212) 509-0022	Universal	Non-Violent Campus Norms
Responding In Peaceful and Positive Ways (RIPP)	Problem-solving model used to reduce fights and incidents of being threatened by a weapon	Aleta Meyer, Life Skills Center Virginia Commonwealth University 800 W. Franklin P.O. Box 842018 Richmond, VA 23284 (888) 572-1572	Universal	Non-Violent Campus Norms
Teaching Students to be Peacemakers	Participants learn how to establish a peer mediation and school discipline program as a classroom	Linda Johnson Interaction Book Company 7208 Cornelia Dr. Edina, MN 55435 (612) 831-7060	Universal	Non-Violent Campus Norms

Program Name	Description	Contact Information	Target	Domain
Good Behavior Game	Preventing antisocial behavior in disruptive children in first grade	Sheppard G. Kellan Dept. of Mental Hygiene Johns Hopkins University School of Hygiene and Public Health Prevention Research Center Mason F. Lord Blvd., Suite 500 5200 Eastern Ave. Baltimore, MD 21224 (410) 550-3445	Universal	Schooling Process and Structure
Pro-Social Classroom Program	Cognitive/effective curriculum for elementary school students	Audrey Clarkin Edgewood School 1 Roosevelt Place Scarsdale, NY 10583 (914) 721-2706	Universal	Schooling Process and Structure
BASIS	Program for middle schools that focuses on procedures for discipline	Denise Gottfredson University of Maryland Department of Criminology Lefrak Hall, Room 2220 College Park, MD 20742 (301) 405-4717	Universal	School Discipline and Positive Support
Adolescent Group Counseling in Schools	All students in Grades 5-12	Fred Kreig 1201 Main St., #700 Wheeling, WV 26003	School-Based Intensive	Relationship Building and Bonding
Families and Schools Together (FAST)	For children ages 3-14 and their parents after a referral by an elementary school teacher. FAST bonds communities, schools, and families by reaching out to them	Lynn McDonald University of Wisconsin - Madison 1025 W. Johnson St. Madison, WI 53706 (608) 263-9476	School-Based Intensive	Relationship Building and Bonding
Gang Risk Intervention Program	A program targeting middle and high school students in order to keep youth out of gangs	Chuck Nichols Safe Schools and Violence Prevention Office California Dept. of Education 560 J Street Sacramento, CA 95814 (916) 323-1026	School-Based Intensive	Relationship Building and Bonding
Kid Power Program	Designed to prevent multiple-risk students from becoming involved with alcohol and other drugs and from being violent	Mike Bennett Assistant Executive Director River Region Human Services, Inc. 1330 W. State St. Jacksonville, FL 32202 (904) 359-6571	School-Based Intensive	Relationship Building and Bonding

Appendix continued p. 146

Appendix continued

Program Name	Description	Contact Information	Target	Domain
Reconnecting Youth	Targets grades 9-12	National Educational Services P.O. Box 8 Bloomington, Indiana 47402 (800) 733-6786	School-Based Intensive	Relationship Building and Bonding
School-Based Depression Prevention/ Intervention Project	Psychoeducational group approach for students in grade 5 at risk for depression	Robbie Sharp Baylor College of Medicine 3355 W. Alabama, #585 Houston, TX 77098 (713) 961-0651	School-Based Intensive	Relationship Building and Bonding
The Anger Coping Program	For middle school male students. Lessons emphasize self-management and self-monitoring, perspective taking, and social skills	John Luchman Department of Psychology University of Alabama P.O. Box 870348 Tuscaloossa, AL 35487 (205) 348-5083	School-Based Intensive	Individual Student Skill Development
At-Risk Prevention Program	Mentoring program, parenting education, monitoring of students, bully proofing and social skills training, extra-curricular activities, counseling, and staff training	Cathy Lines, Ph.D. Educational Student Center 4700 South Yosemite Englewood, CA 80111 (303) 486-4234	School-Based Intensive	Individual Student Skill Development
BrainPower	Designed to reduce peer-directed aggression in boys in late elementary school	Cynthia Hudley Gevirtz Graduate School of Education University of California Santa Barbara 2210 Phelps Hall, UCSB Santa Barbara, CA 93106 (805) 893-8324	School-Based Intensive	Individual Student Skill Development
ThinkFirst	Anger and aggression management training for secondary level students	Jim Larson, Coordinator School Psychology Program Department of Psychology University of Wisconsin - Whitewater Whitewater, WI 53190 (414) 472-5412	School-Based Intensive	Individual Student Skill Development
Enhance Social Competency Program	Kindergarten and pre-kindergarten students at risk for school adjustment and learning problems	Halina Marshall Primary Mental Health Project 575 Mount Hope Ave. Rochester, NY 14620 (716) 273-5957	School-Based Intensive	Individual Student Skill Development

Program Name	Description	Contact Information	Target	Domain
The School Safety Program	Identifies violence problems and devises effective responses in high school	Dennis Kenney, Director of Research Police Executive Research Forum 1120 Connecticut Ave. NW, Suite 930 Washington DC, 20036 (202) 466-7820	School-Based Intensive	Non-Violent Campus Norms
Project PATHE	Reduces school disorder and improves school environment; treatment for low-achieving and disruptive students	Denise Gottfredson Center for Social Organization of Schools Johns Hopkins University 3305 N-Charles St. Baltimore, MD 21218 (410) 516-8808	School-Based Intensive	Schooling Process and Structure
The School Transitional Environment Program	Organizational change in large middle and high schools to facilitate successful adaptation primarily by disadvantaged students	Dr. Peter Mulhall Director Center for Prevention, Research, and Development Institute of Government and Public Affairs University of Illinois Champaign, IL 61820 (217) 333-3231	School-Based Intensive	Schooling Process and Structure
Collaborative Evening Parent Training Classes	Parents of at-risk and behaviorally disordered children and youth	Paula Laidig Stonebridge Elementary School 900 N. Owen St. Stillwater, MN 55082 (651) 351-8700	Community School-Family Based	Relationship Building and Bonding
CSRA Transitional Center	Public school and community-based prevention initiative	Charles Bartholomew, Ph.D. Psychological Services Richmond Co. Board of Ed. 3110 Lake Forest Drive, Bldg. 210 Augusta, GA 30909 (704) 731-8716	Community School-Family Based	Relationship Building and Bonding
Community Health Outreach	Integrates physical and mental health care and community; training for parents, teachers, health care providers	William Allen Cherokee Health Systems 6350 W. Andrew Johnson Hwy. Talbot, TN 37877 (423) 581-3673	Community School-Family Based	Relationship Building and Bonding

Appendix continued p. 148

BEST COPY AVAILABLE

Appendix continued

Program Name	Description	Contact Information	Target	Domain
Parent/Child Counseling Program	Parents and children preschool through high school	Richard Lloyd Warwick Public Schools 34 Warwick Lake Ave. Warwick, RI 02889	Community School-Family Based	Relationship Building and Bonding
Multisystemic Therapy	Chronic, violent, or substance-abusing juvenile offenders, ages 12-17 at risk of out-of-home placement, and their families	Scott W. Henggeler Family Services Research Center Medical University of South Carolina 67 President St. #CPP P.O. Box 250861 Charleston, SC 29425 (843) 876-1800	Community School-Family Based	Relationship Building and Bonding
Vermont State Agency of Human Services Department of Developmental and Mental Health Services: Success Beyond Six	Variety of mental health services offered in schools, especially in case management for people from birth to adulthood	Brenda Bean Success Beyond Six 103 S. Main St. Waterbury, VT 05671 (802) 241-2630	Community School-Family Based	Relationship Building and Bonding
Midwestern Prevention Project	Program to reduce substance use for children aged 10-15	Angela Lapin, Program Manager Center for Prevention Policy Research Dept. of Preventive Medicine University of Southern California 11441 East Lake Ave., MS 44 Los Angeles, CA 90033-0800 (323) 865-0325	Community School-Family Based	Individual Student Skill Development
Bully Proofing Your School	Focuses on shifting power away from bullies, not on punishing them	Carla Garrity, The Bully Project 5290 East Yale Circle, Suite 207 Denver, CO 80222 (303) 649-8496	Community School-Family Based	Non-Violent Campus Norms
The Bullying Prevention Project	Identifies and intervenes with bullies and their victims	Susan Limber, Project Director Bullying Prevention Project Institute for Families in Society Univ. of South Carolina, Carolina Plaza Columbia, SC 29208 (803) 737-3186	Community School-Family Based	Non-Violent Campus Norms

Program Name	Description	Contact Information	Target	Domain
Behavior Consultation Team	District-level intervention team trained to serve children in pre-kindergarten to 6th grade	Jim McDougal Pupil Services Division Syracuse City School District 725 Harrison Ave. Syracuse, NY 13203 (315) 435-4676	Community School-Family Based	School Discipline and Positive Support
Project BASIC	Teaches mental health skills, links community mental health services, builds supportive school setting	Jama McDonald & William Allen Project BASIC 2013 Cherokee Bluff Dr. Knoxville, TN 37920 (423) 586-0614	Community School-Family Based	Enhancing School Climate
Dating Violence Prevention Program	A program for high school students designed to change attitudes condoning dating violence	K.D. O'Leary Department of Psychology State University of New York at Stony Brook Stony Brook, NY 11794-2500 (631) 632-7852	Victim Support	Non-Violent Campus Norms
Safe Dates	A program for grades 8 and 9 to change norms relating to dating violence	Vangee Foshee Department of Health Behavior and Health Education School of Public Health University of North Carolina at Chapel Hill Campus Box 7400 Chapel Hill, NC 27599 (919) 966-6616	Victim Support	Non-Violent Campus Norms

BEST COPY AVAILABLE

8

危機

Promoting Social Skills and Development of Socially Supportive Learning Environments

Stephen N. Elliott, Ph.D.
Wisconsin Center for Education Research
University of Wisconsin-Madison

Brian C. McKevitt, Ph.D.
University of Wisconsin-Madison

James Clyde DiPerna, Ph.D.
Lehigh University

Social skills are important to the successful social and academic functioning of all students and play a significant role in avoiding or preventing negative responses from others. Social skills are also important aspects of effective schools. As evidence of this perspective, the U.S. Department of Education published a guide for school-based professionals regarding strategies for crisis prevention and intervention. This guide, entitled *Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer, Osher, & Warger, 1998), identified a number of characteristics of school environments that facilitate effective crisis prevention, intervention, and response in schools (see Table 1, on page 152). Several of the characteristics (displayed in bold) identified in the table reflect the importance of children's social functioning in preventing crises.

Behaviors such as sharing, helping, initiating communications, requesting help from another person, and giving compliments are universally considered socially desired behaviors and commonly referred to as social skills. In general, social skills may be defined as socially acceptable learned behaviors that enable a person to interact with others in ways that elicit positive responses and assist in avoiding negative responses (Gresham & Elliott, 1984). The acronym of CARES can be used to identify five major clusters of social skills—cooperation, assertion, responsibility, empathy, and self-control—that have been shown to be in the repertoire of socially competent individuals (Elliott & Gresham, 1991).

Social skills training covers a wide range of interventions that emphasize the acquisition and performance of prosocial behaviors and typically use nonaversive methods to

Table 1

Characteristics of Schools That Facilitate Crisis Prevention and Intervention

- Focus on academic achievement
- Involve families in meaningful ways
- Develop links to the community
- **Emphasize positive relationships among students and staff**
- **Discuss safety issues openly**
- **Treat students with equal respect**
- **Create ways for students to share their concerns**
- **Help children feel safe expressing their feelings**
- Have in place a system for referring children who are suspected of being abused or neglected
- Offer extended day programs for children
- **Promote good citizenship and character**
- Identify problems and assess progress toward solutions
- Support students in making the transitions to adult life and the workplace

Note
The boldfaced items are commonly part of social skills training programs.

teach these prosocial behaviors. Some social skills interventions, however, concurrently focus on the reduction of interfering problem behaviors as well as the teaching of prosocial behaviors. Thus, social skills training has four primary objectives: (a) promoting social skills acquisition, (b) enhancing social skills performance, (c) reducing or removing interfering problem behaviors, and (d) facilitating the generalization and maintenance of social skills (Gresham & Elliott, 1990).

Common social skills training tactics can be characterized as teacher or psychologist directed, teacher or psychologist and peer directed, or peer directed. These procedures can be further categorized into three theoretical approaches (i.e., operant, social learning, and cognitive-behavioral) that differ according to the focus of treatment (e.g., children's thinking and problem-solving skills, children's behavior) and to their active treatment procedures (e.g., modeling, reinforcement of appropriate behavior). Regardless of theoretical approach, teaching social skills involves many of the same methods as teaching academic concepts. Effective teachers of both academic and social skills model correct or appropriate behavior, elicit an imitative response, provide corrective feedback, and arrange for opportunities to practice the new skill. A large number of intervention procedures have been identified for teaching social skills to children. These procedures are based on the assumption that children learn social skills through the processes of observational and instrumental learning (Elliott & Gresham, 1991).

In the remainder of this chapter, we examine the basics of social skills training, provide an overview of the effectiveness of social skills training, and then focus on the use of social skills training as part of interventions for aggressive behavior, depression, and classroom functioning. In concluding the chapter, we examine a schoolwide approach to social skills training called the Responsive Classroom. This model program focuses on the skills embodied in the CARES framework and illustrates that social skills help create a socially supportive environment for the development of healthy and academically oriented students.

Social Skills: An Important Part of Schooling and Supportive Environments

Socialization and the development of social skills are important goals of schooling, although several observers have characterized social skills training efforts to be part of a hidden curriculum because they are usually not explicitly targeted or taught (Stephens, 1978). When children do not develop social skills that are essential for successful interpersonal adjustment, they are at risk for a variety of social-emotional difficulties and poor academic performance (Cartledge & Milburn, 1995; Parker & Asher, 1987). Conservatively, we estimate 15 to 20% of the school-age population have poorly developed social skills. Given that many of these students with poor social skills will not be identified as students with disabilities, there is a good chance they will not be treated and may become part of a growing crisis in the delivery of mental health services. Embedding social skills programs into schools and directly focusing on the promotion of social skills and adaptive interpersonal behaviors makes sense from a preventative mental health perspective. In addition, when the research on academically competent students is examined we find an even stronger argument for ensuring that schools teach children social skills because such skills appear to be part of a set of skills that function as academic enablers (DiPerna & Elliott, 2000; Malecki & Elliott, 1999; Wentzel, 1993).

Social Skills as Academic Enablers

Several researchers have established that a direct relationship exists between social skills and academic functioning (Bursuch & Asher, 1986; Elliott, 1993, 1995; Malecki, 1998). Differences in social functioning between students with learning disabilities and normally achieving students have been found to be as large as two standard deviations apart on widely used instruments such as the Social Skills Rating System (Gresham & Elliott, 1990). Similar results have been found for the differences between students with mild disabilities and students without disabilities (Gresham & Reschly, 1987; Gresham, Elliott, & Black, 1987). Other investigators have reported significant relationships between teacher-rated social skills and direct observations of academic time-on-task or engaged time and academic responding (Eisert, Walker, Severson, Black, & Todis, 1987; Elliott, Gresham, Freeman, & McCloskey, 1988). Thus, there is strong and consistent support for a relationship (as evidenced by moderate to high correlations) between academic achievement and social skills functioning.

Until recently, however, there has been less published evidence that social skills have a *direct, causal* effect on academic achievement. One of the key studies that best illustrates that students' prosocial classroom behaviors have a direct, causal effect on their academic achievement, as operationalized by grades or standardized test scores, was conducted by Wentzel (1993). Wentzel studied the causal effects of 423 sixth- and seventh-grade students' prosocial and antisocial behaviors on their GPAs and Stanford Test of Basic Skills (STBS) scores. Statistically, she found that prosocial and antisocial behavior were independent predictors of students' GPAs and that prosocial behavior was an independent predictor of STBS scores. Wentzel reported that students' prosocial behavior in the classroom has a direct and statistically significant effect on their GPA, as does their antisocial behavior. Both types of behavior also have a direct and statistically significant effect on teacher-rated academic behavior (i.e., interest in learning, works independently, etc.), which in turn has a very large influence on GPA.

Social Skills as Part of Socially Supportive Environments

The social skills of individual students influence not only their academic functioning, but also the school environment. The collective effect of socially skilled individuals is the construction of socially supportive environments. Social support has been identified as one of the most important variables in the development of mentally and physically healthy individuals (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Nolten (1994) defined social support as "prosocial behaviors or attitudes from a variety of sources directed toward an individual that strengthen his or her functioning" (p. 2). At least three types of social support have been identified: emotional, instrumental, and appraisal support. Emotional support refers to the caring aspects of social support, such as provision of trust, empathy, and love. Instrumental support involves helping behaviors such as financial support or volunteering time and skills. Appraisal support is evaluative feedback; for example, a teacher might say; "You're doing a great job." Key sources of social support for students are parents, teachers, classmates, and close friends, although the importance of these sources changes over time (Malecki, 1998).

Numerous investigations outside of school psychology have reported that the perceived social support of an environment is particularly important to adolescents (e.g., Cauce, Felner, & Primavera, 1982; Wenz-Gross & Siperstein, 1997). Recent work by Nolten (1994) and Malecki and Elliott (in press) has led to the development of the Student Social Support Scale, an instrument for assessing students' perceptions of their school environment. This instrument has been used in several schoolwide evaluation projects of the Responsive Classroom approach (Elliott, 1997, 1999). A consistent finding in these studies has been the strong positive correlations between students' social skill ratings and their own ratings of the social support of the school environment. On average, the correlations have been +0.67. Although not an indication of causation, it is clear that social skills and social support frequently co-occur. For students to use the support offered in their environment, they need to be socially skilled enough to recruit support and to reinforce those who provide it. We will say more about social skills and socially supportive environments and, in particular, the Responsive Classroom approach later in this chapter.

Social Skills Training Basics

Five fundamental assumptions are central to the development, assessment, and treatment of social skills:

Assumption 1: Social skills are primarily acquired through learning that involves observation, modeling, rehearsal, and feedback.

Assumption 2: Social skills include specific, discrete verbal and nonverbal behaviors.

Assumption 3: Social skills require specific behaviors that are effective in initiating, maintaining, and terminating interpersonal interactions and relationships.

Assumption 4: Social skills are interactive by nature and entail effective and appropriate behavioral performances.

Assumption 5: Social skills are situationally specific behaviors and are influenced by the characteristics, demands, and expectations operating in specific environments.

Although a number of procedures, such as modeling, coaching, cognitive problem solving, and discrimination training, have been developed to teach social skills, four fundamental processes underlie all social skill intervention techniques. Ladd and Mize (1983) termed these processes "training variables." These training variables are (a) instruction, (b) rehearsal, (c) reinforcement or feedback, and (d) reductive processes.

Both qualitative and quantitative reviews of the social skills training literature (Elliott & Gresham, 1993; Gresham, in preparation; Schneider, 1992) suggest that social skills training is an effective intervention for changing social behavior and, to a lesser extent, in promoting generalization and maintenance of social skills, peer acceptance, and reducing antisocial behavior. McIntosh, Vaughn, and Zaragoza (1991) reviewed 22 social skills training studies conducted with 572 children identified with learning disabilities. Social skills training strategies primarily included combinations of modeling, coaching, behavioral rehearsal, role-playing, and feedback. This review indicated that 14 out of the 22 studies (approximately 64%) showed positive training effects. Specifically, researchers found that studies showing positive effects of intervention provided more than three times as much social skills training as studies not showing intervention effects. McIntosh et al. also reported that studies where investigators matched social skills deficits with intervention strategies were more likely to show positive results. Zaragoza, Vaughn, and McIntosh (1991) reported similar effects of social skills training in their review of 27 studies conducted with children with behavior disorders.

In a meta-analytic review, Schneider (1992) reviewed 79 controlled outcome studies of social skills training. Effect size estimates indicated that social skills training was most effective with withdrawn children (r = 0.69) and least effective for children described as aggressive and unpopular (r = -0.37). In terms of outcome variables, social skills training produced the largest effect on social interaction (r = 0.42) and lower effect sizes for aggression (r = 0.20) and peer acceptance (r = 0.22). Schneider demonstrated statistically that an effect size between 0.2 and 0.3 suggests that between 60 and 65% of the students receiving social skills training would improve compared with only 30 to 35% of the subjects not receiving social skills training.

In summary, both qualitative and quantitative reviews of social skills training research indicate that it can be effective in changing children's social behavior. Practical suggestions from the research literature include the extensive use of operant methods to reinforce existing social skills. Basic operant methods include the manipulation of environmental conditions to create opportunities for social interactions that prompt or cue socially desired behavior in a child and the manipulation of consequences so that socially appropriate behavior is reinforced and socially inappropriate behavior, whenever possible, is ignored rather than punished.

Social Skills Training as Part of Crisis Prevention Efforts

The teaching and modeling of social skills have been included as part of proven intervention programs for remediating socially disruptive behavior and uncontrollable anger (e.g., Kazdin, 1996; Kolko, 1996; Lochman, 1992; Webster-Stratton, 1996) and depression (e.g., Lewinsohn, Clarke, Rohde, Hops, & Seeley, 1996; Stark et al., 1998). Although these programs are designed for children and adolescents already displaying problematic behaviors (i.e., tertiary prevention), they also can be conceptualized as crisis prevention programs, in the sense that they may prevent future disruptive behavior or potential crises (e.g., school violence, suicide) from occurring. It is important to note, however, that little, if any, research exists on the efficacy of social skills training for the primary prevention of school crises. Although there are many published social skills curricula (e.g., Second Step), empirical support for their role in preventing future crises is lacking. The literature that currently exists demonstrates the efficacy of tertiary prevention or intervention programs, which include social skills training, for the remediation of possible crisis-causing behavior. It is also important to note that social skills training is a component of these efficacious intervention programs. It is difficult to know the extent to which the social skills training itself is responsible for behavior change without rigorous empirical study. Nevertheless, a description of the role of social skills training in intervention programs is useful for conceptualizing how social skills training might be useful for preventing crisis events. In this section, we describe several of these programs.

Socially Disruptive Behavior and Aggression

Disruptive behaviors, including aggression and clinical disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD), in childhood can lead to antisocial, delinquent, and criminal behaviors in later childhood and young adulthood (Hinshaw & Anderson, 1996). Children with significant disruptive behaviors often demonstrate a lack of social concern and can display volatile and aggressive behaviors that can lead to crises.

Research has found that children who display aggressive behavior have specific deficits or distortions in their processing of information that in turn influence their anger or aggressive behavior (Feindler, 1991; Lochman, Dunn, & Klimes-Dougan, 1993). Aggressive children focus on the hostile cues in a social situation and interpret events on the basis of these cues. They also are more likely than nonaggressive children to perceive that others are acting with hostile intentions. Children with anger-control deficits underestimate the aggressiveness of their own actions and overestimate the aggressiveness of others. Furthermore, aggressive children act on problem solutions that are less socially competent and involve action-oriented efforts rather than verbal strategies. Aggressive children believe aggressive solutions will have more positive than negative consequences, thus increasing the likelihood they will resort to aggression in conflict situations. Finally, aggressive children are unskilled at acting on more adaptive problem-solving strategies. Thus, aggression has both cognitive components (i.e., distorted perceptions of others' intentions, belief that aggressive behavior will lead to mostly positive consequences) and behavioral components (i.e., acting aggressively as problem solutions, lacking behavioral skills to react to situations adaptively). Social skills and social problem-solving training have been included as components in several empirically supported interventions for children with disruptive behavior disorders to improve their social problem-solving and interpersonal skills as they relate to the cognitive distortions and behavioral deficits associated with aggression (Lochman et al., 1993; Lochman & Dodge, 1994).

Social problem-solving training. The focus of social problem-solving training is to teach children skills to react to problem situations, with the idea that inappropriate reactions to anger-provoking situations reflect deficits in thinking skills, social skills, or problem-solving skills (Shapiro & Cole, 1994). Although there are many problem-solving training programs, social problem-solving models incorporated within them generally follow a similar sequence. Children are taught how to recognize a problem situation, define what the problem is, generate alternative solutions, evaluate the alternatives by estimating the consequences of each, make a decision about which solution to use, implement the solution, and finally see if the chosen solution was effective.

There are several published social problem-solving programs and curricula (for a comprehensive list see Cartledge & Milburn, 1995). Two such programs are the I Can Problem Solve (ICPS) program developed by Shure (1992) and the Think Aloud program developed by Camp and Bash (1985). The general goal of these programs is to teach children ways to think through problems rather than to teach the solutions to specific problems (Shapiro & Cole, 1994). A typical component of social problem-solving programs is social skills training (Shapiro & Cole, 1994). Social skills training employs behavioral learning techniques, such as verbal instruction, modeling, role-playing, rehearsal, and feedback to teach children specific prosocial skills to replace maladaptive aggressive behaviors. Social skills curricula are numerous, and generally follow a similar sequence of introducing new skills, having children practice those skills, providing feedback for children's performance of those skills, and teaching generalization of skills to real-life settings. Specific social skills that can be addressed are tone of voice, cooperation and sharing, asking permission, paying compliments, and responding to teasing.

Outcome studies on the aforementioned programs generally have yielded favorable results (Shapiro & Cole, 1994). Controlled studies have looked at the Think Aloud program and found positive changes in behavior and teacher perceptions of aggressive children relative to control groups. In a study by Camp, Blom, Hebert, and van Doorninck (1977), however, aggressive boys showed improvements in prosocial behavior following the Think Aloud program, but not in their observable problem-solving skills. Nevertheless, problem-solving training combined with social skills training, relaxation training, and instructive self-talk has demonstrated success in reducing aggressive behavior (Kendall & Cummings, 1988).

Anger Coping Program. The Anger Coping Program, developed by Lochman and colleagues (1993), is a school-based anger management program typically implemented in 18 weekly group sessions for 45 minutes to 1 hour each. Groups usually consist of four to six children identified by school personnel as aggressive and disruptive. The groups address topics of perspective taking, awareness of arousal, self-instruction to inhibit aggressive responses, and social problem solving—all aspects of children's social and interpersonal skills.

One important aspect of the Anger Coping Program is its focus on promoting and enhancing generalization of the skills learned in groups (Lochman et al., 1993). Universal intervention and teacher consultation are incorporated into the program to enhance generalization. Universal intervention focuses on incorporating skills taught in small groups into the students' classrooms. Children who participate in small groups are exposed to the ideas and skills of the group in their classroom settings. Teachers are trained in the activities of the group and continue to have students practice skills after the group is over. Trained teachers also can monitor students' use of social skills and problem solving on a day-to-day basis, provide cues and feedback, and reinforce use of adaptive skills. Thus, with universal intervention, the learning from the group continues after the group sessions are over.

Lochman et al. (1993) provided evidence for the efficacy of the Anger Coping Program. Children who went through the Anger Coping Program had significantly lower rates of disruptive and off-task behavior, according to independent observers and parent ratings. Perceived social competence improved, as well as teachers' ratings of aggression. Lochman (1992) found that just after going through the Anger Coping Program, 31 boys had lower rates of drug and alcohol involvement and had higher levels of self-esteem and problem-solving skills than boys who did not go through the program. Three years after going through the Anger Coping Program, participants were not significantly different from nonaggressive boys in these variables. Such a finding suggests that the program had some long-lasting effect on behavior.

Problem-solving and parent management training. Kazdin (1996) described a program that combines features of problem-solving skills training and parent management training to remediate aggressive behavior in children diagnosed with conduct disorder. In 20 weekly sessions, children are taught problem-solving steps and apply them to everyday situations. The problem-solving steps are verbal self-statements (e.g., "What am I supposed to do?" "I have to look at all my possibilities," "I had better concentrate and focus in," "I need to make a choice," and "I did a good job," or "Oh, I made a mistake."). Role-plays along with a variety of materials and tasks are used to practice newly developed problem-solving skills. Situations with different kinds of exchanges and various people are role-played to promote generalization and maintenance.

The parent management training component to the program lasts for 16 sessions conducted weekly (Kazdin, 1996). Sessions consist primarily of teaching parents skills, such as positive reinforcement and contingencies, to change children's behavior. Parents are taught how to implement a token reinforcement system at home that prompts them to practice new skills and to reinforce appropriate behavior. Parent training also encourages parents to monitor school performance through contacts with the teacher and to provide consequences (both positive and negative) at home for school behavior.

Empirical support for this program is strong (Kazdin, 1996). Research has indicated that problem-solving skills training alone or in combination with parent management training reduces antisocial behavior (deviance, aggressive, or delinquent behavior) and increases prosocial behavior. Effects of treatment span home, school, and the community and are present up to 1 year after treatment. Improvements are evident in child behavior and in parent stress and depression.

Parent training and social skills training through videotape. Webster-Stratton (1996) described another effective program that incorporates social skills training, social problem-solving instruction, and parent training. Through separate videotapes, skills necessary to improve behavior are modeled for parents and children. Skills addressed in the three-videotape series for parents include praise, rewards, limit setting, discipline (BASIC), problem solving, anger management, communication (ADVANCE), and involvement in children's academics and school performance (PARTNERS1). Skills demonstrated in the videotape series for children (KIDVID) include social skills, problem solving, anger management, and good classroom behavior. Problem-solving and social skills training are taught via modeling on the videotaped vignettes and in-group role-plays and activities.

Research on the effectiveness of the videotape training has found the programs to be successful in improving parent skills and child behavior (Webster-Stratton, 1996). The parent tapes were effective in making parents more positive, less contradicting, and less critical of their children. Marital communication, problem solving, coping skills, and parenting skills all improved as a result of the parent sessions, as well as children's prosocial skills. Children's videotapes and group sessions were effective, when compared with a treatment group, in improving problem-solving and conflict management skills. One year after treatment, all improvements were maintained.

In summary, social skills and social problem-solving training have been incorporated into a number of empirically supported interventions that address disruptive behavior, aggression, and anger problems, which all may lead to potential violent and/or crisis situations. Researchers have demonstrated that children with disruptive behavior problems and aggression show distortions or deficits in their social skills and problem-solving abilities. Thus, it is probable that primary prevention programs designed to teach social skills and social problem solving to children before significant problems arise may ward off potential crises. Still, research is needed to prove the efficacy of social skills training for preventing crises associated with disruptive behavior, aggression, and violence.

Depression

Social skills training is also a component of several intervention programs aimed at reducing depressive symptoms in children and adolescents. Depression in children can manifest itself as depressed mood, irritability, somatic complaints, and disinterest (Hammen & Rudolph, 1996). Suicidal thoughts and attempts are included in the diagnostic criteria for major depression. Suicide attempts, whether they occur in school, at home, or in the community, can lead to tragic and traumatic crises for families, peers, and community members. Several studies have linked depression to self-reports of poor social skills, inappropriate assertiveness, and submissiveness (Hammen & Rudolph, 1996). Thus, social skills training as a component to intervention for depression may be effective in teaching interpersonal and social problem-solving skills to children to prevent possible crises associated with depression. Two empirically supported intervention programs that include social skills training for depression are described below.

Cognitive-behavioral treatment for adolescents. Lewinsohn and colleagues (1996) developed a cognitive and behavioral group therapy course that helps depressed patients identify pessimistic thoughts and inappropriate causal attributions. Their *Adolescent Coping with Depression* course (CWD-A) is:

> Based on the premise that teaching adolescents new coping skills and strategies will allow them to counteract the putative causal factors that contribute to their depressive episode and deal more effectively with the problems posed by their environment. Treatment is intended to help adolescents overcome their depression and to enable them to effectively deal with future occurrences of the putative risk factors. (p. 113)

One significant component of the course focuses on increasing social skills. Social skills training occurs throughout the 8-week course and includes training in conversation techniques, planning social activities, and strategies for making friends (Lewinsohn et al., 1996). The course uses other cognitive and behavioral techniques to teach children to increase pleasant activities, decrease anxiety, reduce depressive cognitions, resolve conflicts, and plan for the future.

In clinical trials, the CWD-A course was found to lead to recovery rates significantly higher for the treatment group than for the wait-list control. In one trial, mean scores on the Beck Depression Inventory (BDI) dropped from 21.5 to 8.3 for the children in the treatment groups. In a second trial, mean scores on the BDI dropped from 26.4 to 11.6 for the treatment groups, and 67% of the teenagers in the treatment conditions no longer met diagnosable criteria versus 48% in the wait-list control group (Lewinsohn et al., 1996). Clarke et al. (1995) have modified the intervention program and developed a school-based prevention program for adolescents with elevated scores on a depression inventory. Following participation in the program, significantly fewer adolescents developed major depressive disorder or dysthymia than did those in the control group. Thus, the application of this intervention as a prevention program shows promise.

School-based group treatment for depressive disorders. Stark and colleagues (1998) have developed another cognitive behavioral-based group intervention program for depression that includes social skills training. Emphasis in the social skills domain is placed on teaching assertiveness, giving positive feedback, expressing feelings appropriately, giving and accepting compliments, being a good listener, and using problem-solving steps, to name a few. Skills are taught using role-plays and guided practice. Because the intervention occurs in a group context, social skills also are observed and taught as part of the ongoing proceedings of the group. Maladaptive behaviors are identified as they occur, and appropriate skills are taught and rehearsed. Finally, social skills are addressed while children are playing games. The game context provides an opportunity to address turn-taking and rule-following behaviors, as well as problematic interpersonal interactions. In summary, social skills training is embedded into multiple facets of the group intervention.

The group intervention for depression has demonstrated effectiveness in several studies (Stark, Swearer, Kurowski, Sommer, & Bowen, 1996). In one study reported by Stark et al. (1996), following intervention, children in a cognitive-behavioral treatment condition (which includes social skills training) reported significant reduction in severity of depressive symptoms. Compared with a treatment group receiving traditional counseling (e.g., meetings and discussions about problems), the cognitive-behavioral treatment group reported fewer depressive cognitions and symptoms than the counseling group, thus demonstrating the cognitive-behavioral intervention to be effective in treating childhood depression. Research is still needed, however, on the effects of the specific components in the program.

In summary, intervention programs for depression that contain a social skills training component have demonstrated effectiveness in the reduction of depressive symptoms. It is not yet known what the specific effects of social skills training alone are on reducing depressive symptoms. However, prevention programs for depression that contain social skills training may be useful in preventing depressive symptoms from developing, as interpersonal and social skills deficits often are associated with depression. Still, research is needed on the effectiveness of social skills training for the prevention of crises associated with depression.

A Schoolwide Approach to Teaching Social Skills

In the final section of this chapter, we describe one promising schoolwide approach to promoting improved social functioning for all students in a classroom. This approach, known as the Responsive Classroom, was developed almost 20 years ago by two educators, and several evaluation studies examining its impact on teachers' attitudes and children's social and academic functioning have been very encouraging about its role in primary and secondary prevention.

The Responsive Classroom Model

The Responsive Classroom (Charney & Wood, 1981) is an instructional approach that integrates the teaching of social skills *and* academic skills as part of everyday school life. The social behaviors identified at the outset of this chapter and represented by CARES—cooperation, assertion, responsibility, empathy, and self-control—are directly taught and reinforced in the Responsive Classroom approach. This approach is predicated on the belief that classrooms providing socially supportive environments (i.e., facilitate acceptance, positive interpersonal relationships, and responsibility) enable children to learn most effectively. Because socially supportive classroom environments do not just spontaneously arise on their own, teachers must structure classrooms to provide explicit instruction regarding the development and use of prosocial skills. The Responsive Classroom offers one approach for providing instruction in prosocial skills and fostering supportive classroom environments. The Responsive Classroom approach consists of six components that have evolved through the combined efforts of practicing teachers and educational-developmental researchers. These six components include (a) Morning Meeting, (b) classroom organization, (c) Rules and Logical Consequences, (d) Guided Discovery, (e) academic choice time, and (f) assessment and reporting. In the following paragraphs, we briefly review each of these components to provide an overview of the Responsive Classroom approach.

Morning Meeting. Morning Meeting begins each day in a Responsive Classroom. Based on sound early childhood instructional methods, Morning Meeting has synthesized many familiar practices into a coherent and sequenced structure that maximizes development of communication skills for students. Morning Meeting provides students with the opportunity to greet each other, share academic and social news, participate in engaging warm-up activities, and learn about the academic goals for the day ahead. This meeting also provides teachers with an opportunity to teach specific social skills and students with an opportunity to practice these skills in role-play situations. After introducing a social skill in Morning Meeting, teachers can provide feedback (and follow-up instruction) regarding the social skill throughout the school day. During

Morning Meeting, children sit in a circle with their teacher in an effort to build a sense of belonging, significance, and fun. Regardless of students' age or grade level, Morning Meeting is used to establish a positive tone for the entire school day.

Classroom organization. The physical environment is an important consideration in implementing the Responsive Classroom approach. In Responsive Classrooms, teachers pay particular attention to students' physical skills as well as their academic skills. As a result, Responsive Classroom teachers attempt to match furniture, centers, routines, and time devoted to an activity with the current skills of their students. This practice has been a focal point in early childhood classrooms, but the Responsive Classroom approach extends the use of this practice throughout the elementary grades.

Rules and Logical Consequences. Rules and Logical Consequences is a positive approach to discipline in the classroom (Dreikurs, Grunwald, & Pepper, 1982; Glasser, 1965). The primary goal of this approach is to help students develop self-control so they can effectively function within social communities like the classroom environment. Structuring discipline as a learning opportunity for students helps them to interact with other students, adults, and teachers in a caring way. In addition, developing self-control reduces off-task behavior and increases engaged time. This in turn allows children to receive maximal benefits from instruction. To facilitate students' development of self-control, teachers in Responsive Classrooms emphasize modeling, practice, and role-playing of expectations for behavior. In addition, teachers develop and use logical consequences for inappropriate classroom behavior that are fair and consistent with the behavior.

Guided Discovery. Based on the classroom teaching of Charney and Wood (1981), and the research of Piaget (1965), Guided Discovery is an instructional practice designed to introduce students to materials, learning centers, or processes within a teacher's classroom (Charney, 1992). The primary goal of Guided Discovery is to excite students about learning while teaching them how to make good choices within the classroom. Guided Discovery takes children through a carefully planned instructional sequence that begins with an introduction to the potential use of knowledge and ends with students extending concepts through small group or independent activities.

Academic choice time. The Responsive Classroom approach requires teachers to structure classrooms so that student assignments reflect a balance between teacher-assigned work and work that students choose from an array of possibilities. Such choice time allows students to conduct independent and/or cooperative research projects. Choice time also enables students to develop study skills, such as producing work to meet a timeline, and provides students with opportunities to share their work with other students in the classroom.

Assessment and reporting. Finally, the Responsive Classroom approach encourages teachers to use alternative methods to assess students' work and to combine these assessments with more common measures of achievement (e.g., classroom tests, standardized tests). The Responsive Classroom approach also supports reporting student progress to parents on a continuum rather than synthesizing all information into a single grade. Responsive Classroom teachers are expected to engage parents and students in goal setting at the beginning of each year. This early collaboration establishes a foundation for meaningful communications between teachers and parents regarding the student's academic progress throughout the academic year. It also provides an open line of communication regarding the student's classroom behavior and invites parents to become active participants in their child's education.

These six components comprise the Responsive Classroom approach and allow teachers to introduce instruction of social skills in the classroom. In the next section, we briefly highlight the results of initial research exploring the effectiveness of the Responsive Classroom approach.

Responsive Classroom Effectiveness Research

Teachers in more than 100 schools in the United States have been trained to implement the Responsive Classroom approach. Evaluations of the approach have been conducted in several school districts (Elliott 1993, 1995). In particular, evaluations from two school districts where the Responsive Classroom approach was implemented with relatively high integrity in some schools and not implemented in others indicated the following:

1. Students receiving instruction within the Responsive Classroom approach generally were perceived to exhibit higher levels of social skills than students with limited or no exposure to the approach. Cooperation and assertion behaviors of students, in particular, were influenced positively by the approach. In addition, students in Responsive Classrooms were observed to exhibit significantly less problem behavior than did their peers from non-Responsive Classrooms.

2. When implemented with integrity (i.e., regularly and consistent with implementation guidelines), the Responsive Classroom approach was found to be associated with significantly greater gains in students' social and academic functioning than in students from comparison schools where no social problem-solving or social skills curriculum was in use.

3. Different elements of the Responsive Classroom approach had varied effects on students' social functioning and classroom behavior. For example, Morning Meeting was associated with *increases* in social skills, whereas cooperative learning resulting from Guided Discovery was most strongly associated with *decreases* in problem behaviors.

4. The Responsive Classroom approach was associated with greater gains in behavior, on average, for students with disabilities than for students without disabilities. The Responsive Classroom approach also was associated with

greater gains for African American students than a comparison group of Caucasian students.

5. Parents, regardless of socioeconomic level or racial/ethnic group membership, overwhelmingly rated the Responsive Classroom approach as "acceptable" or "highly acceptable." In addition, whether or not they had a child in a Responsive Classroom, parents consistently indicated they would like their child's teacher to use the approach.

A more recent evaluation project (Elliott, 1999) attempted to gain further insights into the effectiveness and acceptability of the Responsive Classroom curriculum as implemented in first- through fifth-grade classrooms. In this project, data were collected from teachers, parents, and students across a two-year period. Results from this project indicated the Responsive Classroom was perceived to be effective by almost all educational stakeholders surveyed. Actual behavior change data with a representative sample of students substantiated this perception. Data collected across both years of the project demonstrated greater improvements in students' social skills and academic behaviors, with concomitant decreases in problem behaviors, for students in Responsive Classrooms when compared with students in non-Responsive Classrooms. Perhaps even more compelling is that the approach appears to create conditions that facilitate improved academic achievement as measured by standardized tests.

In summary, evaluation studies conducted to date indicate that the Responsive Classroom approach is an acceptable and effective method for enhancing the social behavior of young children and appears to create conditions that foster academic achievement. Specific findings replicated across studies include:

- The frequency of students' problem behaviors decreases significantly with a year or more exposure to instruction that is organized and delivered within a Responsive Classroom.

- The frequency of students' social skills improves noticeably in classrooms in which they have consistently been exposed to instruction that emphasizes the Responsive Classroom approach.

- The social skills taught and reinforced in the Responsive Classroom approach seem to function as academic enablers, resulting in improved scores on achievement tests.

Although results from these initial studies are promising, it is important to note that each of the studies reported in this section were evaluation projects with moderate samples and small numbers of schools. Additional research using more rigorous experimental designs with larger samples of students (and schools) is necessary to provide conclusive evidence regarding the effectiveness of this instructional approach in promoting socially supportive environments and improved social and academic functioning for students.

Conclusion

People need to interact with other people to learn, to play, to work, to survive. Individuals who learn how to interact effectively with other people are said to be socially skilled. They possess behaviors that allow them to cooperate, to communicate, to assert, and to control themselves appropriately. Most people learn these social skills through the normal course of their development. However, not all people do and consequently they often have difficulty making the interpersonal adaptations necessary to function effectively at school and work. Some of these difficulties turn into personal and interpersonal crises. Social skills training—cognitive problem solving, modeling, coaching, behavior rehearsal, and reinforcement—can be part of an effective method to prevent or to reduce the impact associated with personal and interpersonal crises. In addition, social skills programs that are introduced schoolwide have the potential to help create socially supportive environments where students can learn and interact safely. In summary, social skills are an important outcome of schooling and play a central role in preventing and/or resolving crises in the lives of students and the educators who work with them.

References

Bursuch, W. D., & Asher, S. R. (1986). The relationship between social competence and achievement in elementary school children. *Journal of Clinical Child Psychology, 15*, 41-49.

Camp, B. W., & Bash, M. S. (1985). *Think aloud. Increasing social and cognitive skills: A problem-solving program for children*. Champaign, IL: Research Press.

Camp, B. W., Blom, G., Hebert, F., & van Doorninck, W. (1977). Verbal mediation in young aggressive boys. *Journal of Abnormal Psychology, 86*, 145-153.

Cartledge, G., & Milburn, J. F. (1995). *Teaching social skills to children and youth: Innovative approaches* (3rd ed.). Boston: Allyn & Bacon.

Cauce, A., Felner, R., & Primavera, J. (1982). Social support in high-risk adolescents: Structural components and adaptive impact. *American Journal of Community Psychology, 10*, 417-428.

Charney, R. S. (1992). *Teaching children to care: Management in the Responsive Classroom*. Greenfield, MA: Northeast Foundation for Children.

Charney, R. S., & Wood, R. (1981). *The Responsive Classroom approach to instruction*. Greenfield, MA: Northeast Foundation for Children.

Clarke, G. N., Hawkins, W., Murphy, M., Sheeber, L. B., Lewinsohn, P. M., & Seeley, J. R. (1995). Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: A randomized trial of a group cognitive interview. *Journal of American Academy of Child & Adolescent Psychiatry, 34*, 312-321.

DiPerna, J. C., & Elliott, S. N. (2000). *The academic competence evaluation scales*. San Antonio, TX: The Psychological Corporation.

Dreikurs, R., Grunwald, B., & Pepper, F. (1982). *Maintaining sanity in the classroom: Classroom management techniques*. New York: Harper & Row.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education.

Eisert, O., Walker, H., Severson, H., Black, A., & Todis, B. (1987). *Adjustment status of kindergarten at risk ratings - rankings, sociometric measure, and direct observations in classroom and free play settings*. Center on Human Development, University of Oregon, Eugene.

Elliott, S. N. (1993). *Caring to learn: A report on the positive impact of a social curriculum*. Greenfield, MA: Northeast Foundation for Children.

Elliott, S. N. (1995). *The Response Classroom: An evaluation of its acceptability and effectiveness*. Greenfield, MA: Northeast Foundation for Children.

Elliott, S. N. (1997). *The Kensington Responsive Classroom study*. Greenfield, MA: Northeast Foundation for Children.

Elliott, S. N. (1999). *The Fitchburg Responsive Classroom evaluation project*. Fitchburg (MA) Public Schools.

Elliott, S. N., & Gresham, F. M. (1991). *Social skills intervention guide*. Circle Pines, MN: American Guidance Service.

Elliott, S. N., & Gresham, F. M. (1993). Social skills interventions for children. *Behavior Modification, 17*, 287-313.

Elliott, S. N., Gresham, F. M., Freeman, T., & McCloskey, G. (1988). Teachers' and observers' ratings of children's social skills: Validation of the Social Skills Rating Scales. *Journal of Psychoeducational Assessment*, 6, 152-161.

Feindler, E. L. (1991). Cognitive strategies in anger control interventions for children and adolescents. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (pp. 66-97). New York: Guilford Press.

Glasser, W. (1965). *Reality therapy*. New York: Harper & Row.

Gresham, F. M. (in preparation). *Social skills interventions: How effective are they?* Unpublished manuscript. University of California, Riverside.

Gresham, F. M., & Elliott, S. N. (1984). Assessment and classification of children's social skills: A review of methods and issues. *School Psychology Review, 13*, 292-301.

Gresham, F. M., & Elliott, S. N. (1990). *Social Skills Rating System*. Circle Pines, MN: American Guidance Service.

Gresham, F. M., Elliott, S. N., & Black, F. (1987). Teacher-rated social skills of mainstreamed mildly handicapped and nonhandicapped children. *School Psychology Review*, 16, 78-88.

Gresham, F. M., & Reschly, D. J. (1987). Dimensions of social competence: Method factors in the assessment of adaptive behaviors, social skills, and peer acceptance. *Journal of School Psychology*, 25, 367-387.

Hammen, C., & Rudolph, K. D. (1996). Childhood depression. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 153-195). New York: Guilford Press.

Hinshaw, S. P., & Anderson, C. A. (1996). Conduct and oppositional defiant disorders. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (pp. 113-154). New York: Guilford Press.

Kazdin, A. E. (1996). Problem solving and parent management in treating aggressive and antisocial behavior. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 377-408). Washington, DC: American Psychological Association.

Kendall, P. C. & Cummings, L. (1988). Thought and action in educational interventions: Cognitive-behavioral approaches. In J. C. Witt, S. N. Elliott, & F. M. Gresham (Eds.), *Handbook of behavior therapy in education* (pp. 403-418). New York: Plenum Press.

Kolko, D. J. (1996). Education and counseling for child firesetters: A comparison of skills training programs with standard practice. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 409-434). Washington, DC: American Psychological Association.

Ladd, G., & Mize, J. (1983). A cognitive-social learning model of social skills training. *Psychological Review*, 90, 127-157.

Lewinsohn, P. M., Clarke, G. N., Rohde, P., Hops, H., & Seeley, J. R. (1996). A course in coping: A cognitive-behavioral approach to the treatment of adolescent depression. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 109-136). Washington, DC: American Psychological Association.

Lochman, J. E. (1992). Cognitive-behavioral intervention with aggressive boys: Three-year follow-up and preventive effects. *Journal of Consulting and Clinical Psychology*, 60, 426-432.

181

Lochman, J. E. & Dodge, K. A. (1994). Social-cognitive processes of severely violent, moderately aggressive, and nonaggressive boys. *Journal of Consulting and Clinical Psychology*, *62*, 366-374.

Lochman, J. E., Dunn, S. E., & Klimes-Dougan, B. (1993). An intervention and consultation model from a social cognitive perspective: A description of the anger coping program. *School Psychology Review*, *22*, 458-471.

Malecki, C. K. (1998). *The influence of elementary students' social behaviors on academic achievement.* Unpublished doctoral dissertation, University of Wisconsin, Madison.

Malecki, C. K., & Elliott, S. N. (in press). Children's social behavior as predictors of academic achievement: A longitudinal analysis. *School Psychology Quarterly.*

Malecki, C. K., & Elliott, S. N. (1999). Adolescents' ratings of perceived social support and its importance: Validation of the Student Social Support Scale. *Psychology in the School*, *36*, 473-483.

McIntosh, R., Vaughn, S., & Zaragoza, N. (1991). A review of social interventions for students with learning disabilities. *Journal of Learning Disabilities*, *24*, 451-458.

Nolten, P. W. (1994). *Conceptualization and measurement of social support: The development of the Student Social Support Scales.* Unpublished doctoral dissertation, University of Wisconsin-Madison.

Parker, J .G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low-accepted children at risk? *Psychological Bulletin*, *102*, 357-389.

Piaget, J. (1965). *The moral judgment of the child.* New York: Macmillan, Free Press.

Schneider, B. (1992). Didactic methods for enhancing children's peer relations: A quantitative review. *Clinical Psychology Review*, *12*, 363-382.

Shapiro, E. S. & Cole, C. L. (1994). *Behavior change in the classroom: Self-management interventions.* New York: Guilford Press.

Shure, M. B. (1992). *I can problem solve: An interpersonal cognitive problem-solving program.* Champaign, IL: Research Press.

Stark, K. D., Swearer, S., Kurowski, C., Sommer, D., & Bowen, B. (1996). Targeting the child and the family: A holistic approach to treating child and adolescent depressive disorders. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 207-238). Washington, DC: American Psychological Association.

Stark, K. D., Swearer, S., Sommer, D., Hickey, B. B., Napolitano, S., Kurowski, C., & Dempsey, M. (1998). School-based group treatment for depressive disorders in children. In K. C. Stoiber & T. R. Kratochwill (Eds.), *Handbook of group intervention for children and families* (pp. 68-99). Boston: Allyn & Bacon.

Stephens, T. (1978). *Social skills in the classroom.* Columbus, OH: Cedars Press.

Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin*, *119*, 488-531.

Webster-Stratton, C. (1996). Early intervention with videotape modeling: Programs for families of children with oppositional defiant disorder or conduct disorder. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 435-474). Washington, DC: American Psychological Association.

Wentzel, K. R. (1993). Does being good make the grade? Social behavior and academic competence in middle school. *Journal of Educational Psychology*, 85, 357-364.

Wenz-Gross, M., & Siperstein, G. N. (1997). Importance of social support in the adjustment of children with learning problems. *Exceptional Children*, 63, 183-193.

Zaragoza, N., Vaughn, S., & McIntosh, R. (1991). Social skills interventions and children with behavior problems: A review. *Behavior Disorders*, 16, 260-275.

183

9

危
機

Bullying in Schools: A Review of Prevention Programs

Carla Garrity, Ph.D.
Neuro Developmental Center (Denver, CO)

Kathryn Jens, Ph.D.
William Porter, Ph.D.
Cherry Creek School District (Englewood, CO)

Sally Stoker, M.S.W.
Steering Committee, Bully-Proofing Your School (Denver, CO)

Educators are confronting the issue of bullying as they focus their attention on creating safe school environments in which teachers can teach and students can learn. The recent high-profile cases of school shootings around the country have highlighted the seriousness of bullying and its sometimes deadly consequences. Despite the recent media scrutiny of school homicides, the actual number of overt incidences of violence in our schools is on the decline (Flannery, 1999). What is not on the decline is the day-to-day, routine bullying that takes place in many of our schools and creates stressful school environments for adults and children alike. Although often overshadowed by the overt acts of youth violence that make headline news, this more pervasive kind of bullying is becoming a focus of prevention efforts for schools and communities.

Bullying is a chronic form of violence that is harmful to many of our students. Because bullying often involves intimidation that silences the victim, the problem of bullying can often be underestimated and overlooked. In fact, when both students and staff are surveyed regarding perceptions of school safety, adults often overestimate student feelings of safety (Barone, 1997; Craig, Pepler, & Atlas; 2000; Madsen, 1966; O'Moore, 2000; Pepler, Craig, Ziegler, & Charach, 1994). According to Smith and Sharp (1994), teachers are aware of only a fraction of the bullying that goes on in their schools, and a study by Nash (1989) reported that teachers grossly underestimated the amount of bullying in their schools and could not identify the majority of their school's hard-core bullies.

Over the past decade, there have been numerous studies on the prevalence of bullying, both in the United States and in other parts of the world. One summary of the literature on bullying states the alarming fact that 15 to 20% of students can expect to experience some form of bullying during their school careers (Batsche & Knoff, 1994). In the United States, one study asked students in the rural Midwest about incidences of bullying in their own school careers. The startling results showed that 80% of high school students reported having been bullied in school and 90% of fourth- through eighth-graders reported having been bullied (Hoover, Oliver, & Hazler, 1992; Hoover, Oliver, & Thompson, 1993). Clearly, bullying is a significant problem, which, if unaddressed, can lead to a climate of fear in the school environment that can significantly compromise the educational process.

Dan Olweus is considered the pioneer in exploring the dynamics of bullying and its effects on school children. He is a Scandinavian researcher who began conducting research on bullying after a series of child suicides in Norwegian schools in the 1980s. His valuable work has inspired other research efforts in Europe, Japan, Australia, Canada, New Zealand, and the United States. Olweus' definition of bullying is widely accepted and often quoted by researchers in the field. He defines bullying as occurring when a person is exposed, repeatedly and over time, to negative actions on the part of one or more persons (Olweus, 1991). The bullying dynamic includes the following key elements: an imbalance of power, repeated actions, intentional actions, and unequal levels of affect. The different forms of bullying include physical aggression, social aggression, intimidation, written aggression, sexual harassment, and racial and cultural harassment (Bonds & Stoker, 2000). It is also important to note that bullying behaviors are varied and range in severity from mild to severe (Garrity, Baris, & Porter, 2000).

Three important groups are involved in the bullying dynamic—bullies, victims, and bystanders—and any successful bullying prevention program needs to address all three groups. In most schools, approximately 6 to 7% of the students are bullies and 9% are victims of bullying behaviors (Greenbaum, Turner, & Stephens, 1989; Olweus, 1993). The other 85% of students are the bystanders, the students in the school who are not actively involved in the bullying dynamics and are not officially identified as bullies or victims (Bonds & Stoker, 2000). Historically, bully prevention programs have always addressed the dynamics and appropriate intervention for both the bully and victim groups. A more recent development has focused on the bystanders and the very important role they can play in both preventing and intervening in the bullying dynamic (Twemlow, Sacco, & Williams, 1996).

The long-term consequence to bullies of their ongoing bullying behavior is often an escalation that leads them down the path of criminal activity and incarceration (Olweus, 1991). Since bullies make thinking errors (e.g., thinking everything should go their way; Samenow, 1989), they often continue their antisocial behavior unless there is appropriate intervention.

The consequences of bullying to victims can be devastating and can affect their academics, health, and social-emotional adjustment. Academic effects include a dislike and avoidance of school as well as a drop in grades. For example, as many as 7% of American eighth-graders stay home at least once a month because of their concerns about being bullied (Banks, 1997; Bonds & Stoker, 2000). If children who are victimized do attend school, it is often difficult for them to concentrate on their academic tasks and their grades can suffer (Hazler, Hoover, & Oliver, 1993). As Ross (1996) stated in her book Childhood Bullying and Teasing, "The damaged feeling of self-worth that results from bullying makes it impossible for the victims to reach their academic and social potential" (p. 91). Victims also experience health problems such as lack of appetite, nervousness, sleep disruption, headaches, and nausea (Rigby, 1998). Finally, victims of bullying can experience adjustment problems, including emotional distress, depression, loneliness, lowered self-esteem, suicidal ideation, and suicidal attempts. Whereas Rigby's work focused on the short-term effects of bullying, Olweus (1992) studied long-term effects, and states that victimization during the middle school years predicts depression and low self-esteem 10 years later, long after the actual bullying has ended.

It is important to note that a child does not have to be a direct victim of physical bullying to feel its impact. Sharp (1995) found verbal bullying to be highly stressful for children. Gutterman and Cameron (1997) confirmed that merely witnessing violence can create serious emotional consequences. The large group of bystanders that exists in every school population—those students not identified as either bullies or victims—can experience anxiety and guilt for not taking action when they witness bullying, which can eventually lower their own self-respect and self-confidence (Bonds & Stoker, 2000; Hazler, 1996). More troubling is the fact that bystanders, both adults and children, who continue to ignore or avoid the issue of bullying can eventually become desensitized to the issue. Their failure to take a stand against bullying behaviors constitutes a silent consent to the perpetrators.

Description of Prevention Programs

Despite the increased attention in the literature to bullying in schools, only a few prevention programs have been developed. Many books give general information about bullying and stress the need for schools to address this problem. For example, Rigby (1996) from Australia and Sullivan (2000) from New Zealand described research on bullying in their respective countries and some intervention ideas such as surveying students and establishing antibullying policies. Yet, these resources do not offer prevention programs. We have selected five bullying prevention programs to review in more detail on the basis of their self-description as a program and on the presence of activities or lessons to do with students.

From research conducted in Norway in the 1980s, Olweus designed the first bullying prevention program that received attention and produced positive results (Olweus & Limber, 1999). This program, called The Bullying Prevention Program, has been replicated both within Norway and in other countries, including the United States.

Olweus' comprehensive program involves interventions at three major levels: schoolwide interventions, classroom-level interventions, and individual-level interventions (Olweus & Limber, 1999). These interventions are all based on a foundation of commitment on the part of adults, both at school and at home, to address bullying and to share responsibility for creating a safe school climate. Olweus, in his program evaluation, documented a 50% reduction in direct bullying two years after the start of implementation. Teachers and students also reported positive changes in school climate. Many of the current bully prevention programs are based on Olweus' original ideas and principles with certain additions and modifications.

Arora (1994) and Batsche and Knoff (1994) have each put forth a set of criteria that bullying interventions should include. Overlapping criteria offered by these authors include establishing antibullying rules, conducting some type of assessment of bullying, and involving parents in the prevention effort. Arora (1994) also emphasized the importance of an integrated whole-school effort. Arora (1994), Craig and Pepler (1995), and Roland (2000) have all stressed the importance of involving peers or witnesses in bullying prevention.

Elliott (1999) found that the most effective programs were those that intervene and change the contextual conditions and interactional dynamics rather than just focus on the individual child. Similarly, Greenfield and Juvonen (1999) highlight the importance of changing the school culture rather than attempting to change individuals.

These criteria will be considered in our review of programs. We begin our review with, and emphasize, our own program, Bully-Proofing Your School, because it was the first prevention program published in the United States and is the most comprehensive of the programs we have reviewed. The last three programs we review are teacher guides or manuals, which in our view, are not comprehensive programs.

Bully-Proofing Your School

Bully-Proofing Your School (Garrity, Jens, Porter, Sager, & Short-Camilli, 2000) was originally developed for elementary schools within the Cherry Creek School District (in Englewood, Colorado), in the early 1990s. Making use of the research of Olweus (1978, 1991, 1993), the authors experimented with program ideas. The bully-proofing program has since been adapted for use with kindergarten and first grades (Garrity et al., 2000) and middle schools (Bonds & Stoker, 2000). A parent's guide for helping children cope with bullying has also been developed (Garrity, Baris, & Porter, 2000).

The Bully-Proofing Your School program is a systemwide program that seeks to impact the context within which bullying occurs. In addition, it adds the element of teaching protective skills to the students and influencing the school climate by engaging the caring majority (i.e., the 85% of children who are neither victims nor bullies). A discipline program for the bullies is based on an understanding of the thinking errors that antisocial children make (Samenow, 1989; see Table 1). A no-nonsense style combined

Table 1

Bully Thinking Errors

Bully Antisocial Thinking	Correct Social Thinking
1. Everything should always go my way.	To be fair, things should go my way half the time and the other person's way the other half of the time.
2. I don't care if I hurt other people.	I feel bad if I hurt other people because I know how it feels to be hurt.
3. Success should come easy and quickly or I'll quit.	I know that success takes hard work and a lot of time.
4. I shouldn't have to follow rules or do boring things.	I have to follow the rules and do my chores like everyone else.
5. Lying can keep you out of trouble.	Lying is the wrong thing to do.
6. I never make mistakes and things are never my fault.	Everyone makes mistakes and things are probably my fault about half the time.
7. Most kids my age are boring and always pleasing adults.	I have a lot in common with kids my age.

with a quick, consistent, and prosocial consequence program replaces the traditional punishment and power struggles that bullies elicit in many schools. A predictable set of consequences for bullying, which requires practicing prosocial actions, replaces suspension, except when a weapon is involved and suspension or expulsion is required by law. The caring majority, in turn, stands up for the victim and expresses the "no bullying" policy of the school. Thus, the program reduces violence in the schools through development of a "caring community" and a "no tolerance for bullying" policy from both students and staff. Recent acts of school violence confirm the importance of mobilizing students not directly involved in bullying. For example, in most of the recent school shootings, some person or persons were aware of the possibility of violence, but failed to report it, or reported it, and no action was taken (Kanan, 1998). More recently, several plans for school violence were successfully averted because of peer reports (Bower, 2001).

The bully-proofing program is implemented in three major phases. Phase One creates the foundation for awareness of the bullying problem that exists. This is done by assessing the climate of the school, providing information about bullying through staff training and, finally, developing schoolwide rules regarding "no tolerance" for bullying. In

BEST COPY AVAILABLE

Phase Two, protective skills and techniques are taught to classroom groups to help students learn strategies for dealing with various kinds of bullying behaviors and to increase their resistance to victimization. Students are encouraged to form a protective, caring group, and the concept of "power in numbers" is emphasized. Phase Three develops the climate throughout the school through promoting a "caring majority." The students who are neither bullies nor victims are taught to stand up for the victims with the promise of adult support. Thus, the "silent majority" is converted to a "caring majority" of students who do not tolerate bullying. The notion of "strength in numbers" is emphasized and discussed with students. Through discussions and role-plays, students understand the importance of supporting each other. They practice using caring behaviors and are encouraged to put these behaviors into actual practice by establishing classroom caring majority groups. Weekly discussions are held in which caring majority behaviors that were exhibited the previous week are discussed and acknowledged. Acts of kindness are celebrated as desired behaviors. Children are rewarded on a continuum that depends on the level of risk demonstrated by the behavior. Thus, a less risky caring behavior, such as asking an excluded child to play, would be acknowledged less intensely than a more risky caring behavior, such as standing up for a student who was being bullied. Whereas many safe school efforts involve bringing in metal detectors and increasing the number of security guards, this program focuses on developing a strong sense of community in which the students speak out against unsafe and mean behaviors. Students let adults know when bullying occurs, and adults work as a team and have the skills and knowledge to intervene. The clear and consistent message is that violence is not tolerated and caring is valued.

Five key components are essential parts of the comprehensive program. These components are discussed here and summarized in Figure 1.

1. Teacher and Staff Training

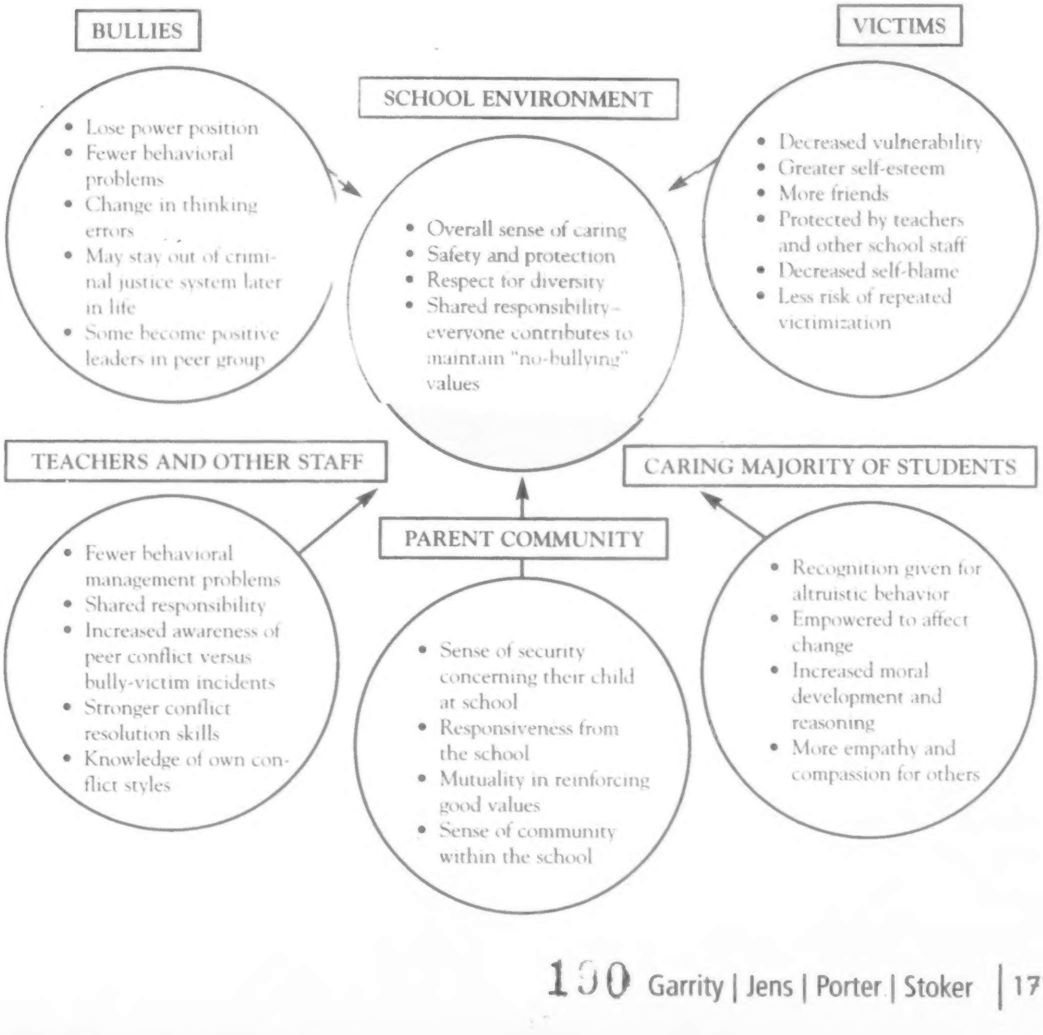
Students need to know that, when bullying occurs, school staff will intervene. Students report that they often remain silent because the staff has told them to solve their own problems, or the staff has intervened and made the situation worse. Staff members need training in knowing the difference between normal peer conflict and bully-victim problems and in how and when to intervene. The staff-training component develops skills in the following areas:

- Distinguishing normal peer conflict from bully-victim problems.
- Characteristics of bullies and victims.
- The serious nature of bullying and the need for adults to help.
- The need for staff cohesion on a zero-tolerance-for-bullying philosophy.
- Awareness of one's own style of conflict resolution and the importance of a variety of styles on a school staff team.

- Effective strategies and disciplinary approaches to use with bullies.
- Effective strategies to support victims.
- Involving the caring students in changing the school climate.
- Reinforcing caring student behavior within the classroom and school.
- Developing and maintaining the caring community.
- Teaching the bully-proofing classroom curriculum.

Figure 1

Bully-Proofing Your School outcomes.


BULLIES
Lose power position
Fewer behavioral problems
Change in thinking errors
May stay out of criminal justice system later in life
Some become positive leaders in peer group
SCHOOL ENVIRONMENT
Overall sense of caring
Safety and protection
Respect for diversity
Shared responsibility-everyone contributes to maintain "no-bullying" values
VICTIMS
Decreased vulnerability
Greater self-esteem
More friends
Protected by teachers and other school staff
Decreased self-blame
Less risk of repeated victimization
TEACHERS AND OTHER STAFF
Fewer behavioral management problems
Shared responsibility
Increased awareness of peer conflict versus bully-victim incidents
Stronger conflict resolution skills
Knowledge of own conflict styles
PARENT COMMUNITY
Sense of security concerning their child at school
Responsiveness from the school
Mutuality in reinforcing good values
Sense of community within the school
CARING MAJORITY OF STUDENTS
Recognition given for altruistic behavior
Empowered to affect change
Increased moral development and reasoning
More empathy and compassion for others

2. Caring Majority of Students/Classroom Intervention

The caring majority of students dramatically influences school climate. This influence is the foundation of the program. The goal is to shift power away from the bullies to the caring majority. This program offers students the skills and knowledge to intervene. These students will help to establish a climate that says: "We treat others kindly in our school."

Early elementary curriculum. The initial curriculum was designed for elementary school students. Designed for kindergarten and first-grade students, this program facilitates the development of basic friendship skills that are prerequisites to bully-proofing. It uses literature and movies to get young children thinking about friendship: what makes a good friend, how to make and keep friends, what to do if other children are not being friendly, how friends can get help for friends, and the difference between tattling and telling. The "HA HA SO" protective skills (see Figure 2) are simplified for young children to: (a) Get help (Help), (b) Stand up for yourself (Assert), (c) Walk away (Avoid), and (d) Say good things to yourself (Self-talk).[1] The children use color posters about friendship and use more hands-on activities than discussion, which is used with older children.

Basic elementary curriculum. The classroom curriculum begins with instructions about the concept of bullying and the administration of a survey. Survey results give students information about the extent of bully-victim problems in their individual classrooms. Next, the students are taught three bully-proofing classroom rules (see Figure 3). In subsequent sessions, the students learn six protective strategies called "HA HA SO" to use when someone is bullying them (see Figure 2). Role-plays are used to practice the strategies. Finally, students learn five strategies to use if they see another student being bullied (see Figure 4, on page 180). The development of these helping behaviors facilitates development of the caring majority.

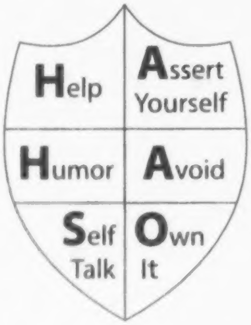
The classroom curriculum is a core component of the program because bullying goes on more frequently and severely when an adult is not present. Thus, it is critical that peers intervene. Children learn the social-emotional concepts involved in the classroom curriculum through discussion (not lecturing) and through schoolwide reinforcement of the concepts. Creating "no bullying" posters to display throughout the school increases the involvement and awareness of all.

Middle school curriculum. Research done on bullying in the United States shows that students report bullying to be the most serious in middle school (Hoover et al., 1992; Ortega & Lera, 2000). Too often dismissed as "just a normal part of adolescence," bullying can be firmly entrenched by the time students reach middle school, with bullies continuing to gain and abuse their power. In turn, victims experience increased helplessness and hopelessness. The unique developmental needs and tasks of the adolescent also contribute to the potential harm caused by bullying in the middle school environment. The adolescent's struggle with identity, the power of the group and of "group think," and the task of working through issues of adult authority all challenge adolescents to experiment with using power appropriately and to maintain a coherent sense of self-identity and

Figure 2

Bully-Proofing Your School shield.

This makes it easy to remember the six things to try when a bully picks on you. They stand for:



- ***Help*** means knowing when and how to get help. Talk about who the adults and other children are who can be counted on.

- ***Assert Yourself*** means learning when to stand up to a bully and when not to. It means looking the bully in the eye and saying, "I don't like you telling untrue stories about me. Stop doing it." This strategy should not be used in instances of severe bullying or if the victim could get hurt.

- ***Humor*** means turning a difficult situation into a funny one. This is a surprise tactic, which usually catches the bully off guard. While effective, this strategy is difficult for a frightened child. Thinking on your feet, especially of something funny, is not easy when you are afraid. Practice good comebacks. This will make it easier to use humor.

- ***Avoid*** means knowing how and when to walk away. This is the strategy most children use, but there is a difference between walking away with confidence and walking away out of fear. Disengagement means walking away with an assertive message. It takes courage and practice, but it is very effective.

- ***Self Talk*** is a way to feel okay about yourself when someone else is putting you down. Children are encouraged to imagine a tape or CD that they put on during difficult moments. It plays good thoughts and positive messages. Help by suggesting some positive statements.

- ***Own It*** means agreeing with the put-down in order to make light of it. This is developing the capacity to laugh at oneself. This strategy is easy to use and very effective. The bully is not expecting the victim to agree. Use it when clothing or hairstyle is being made fun of. When the put-down is something inherent to a child's identity, such as heritage, religion, or disability, this is not a good strategy.

Figure 3

Rules for bully-proofing our classroom.

1. We will not bully other students.
2. We will help others who are being bullied by speaking out and by getting adult help.
3. We will use extra effort to include all students in activities at our school.

Figure 4

What I can do if I see someone being bullied.

CARES

Creative Problem Solving
Adult Help
Relate and Join
Empathy
Stand Up and Speak Out

sound set of beliefs. Without providing practice with the skills to successfully accomplish these tasks, the middle schooler's search for power and identity can take a negative direction and may result in antisocial behaviors such as bullying.

Middle school students are up to this challenge. Adolescence provides an ideal context for educating and empowering students to make themselves and their schools safe through antibullying efforts. Including middle school students in the process of creating safe schools allows them to experiment with their own power in productive ways.

Bully-Proofing Your School: The Middle Years (Bonds & Stoker, 2000) is based on the same core concepts as the elementary bully-proofing curriculum, but is written specifically for middle school students. The curriculum is designed to address the specific developmental needs and tasks of the adolescent and to target the bullying dynamic that is particular to the middle school environment.

The middle school curriculum consists of seven lessons designed for each grade level. Each grade level focuses on a particular theme and includes classroom lessons, class work, and homework. An overview of the themes and topics addressed in the middle school curriculum follows:

1. Sixth Grade—The Basics about Bullying: bullies, definition and types of bullying, normal conflict versus bullying, victims, bystanders, teasing, sexual harassment, HA HA SO strategies, empathy, taking a stand, and including others.

2. Seventh Grade—Creating the Caring Community: review of the basics, caring behaviors, empathy, inclusion, groups, taking a stand, sexual harassment, flirting, creative problem solving, and levels of risk-taking.

3. Eighth Grade—Leadership: review of the basics, sexual harassment, flirting, inclusion, groups, taking a stand, characteristics and styles of positive leadership, intention, and creative problem solving.

It is important to remember that this curriculum is intended to be one part of a comprehensive, systemic, climate change program. The lessons are designed to educate and empower the caring majority of students so that they can learn how to take a stand against bullying and work together to create a safe and caring school community where teachers can teach and students can learn.

3. Bullies

Bullies have a strong need for power and attention, which they gain at the expense of victims. Often lacking in compassion and empathy, many of these bullies need training in prosocial skills and in turning their leadership abilities to positive directions (Arora & Thompson, 1987; Baldry & Farrington, 1998; Bentley & Li, 1995; Berthold & Hoover, 2000; Bosworth, Esplage, & Simon, 1999; Byrne, 1994). Trying to meet the power of the bully head-on is rarely productive because bullies will not give up power. There is a tendency to spend inordinate amounts of time with these students and parents. The use of punishment with bullies is the most common intervention, but it is typically ineffective in changing the bully (Schwartz, 1999). The best intervention is to utilize a no-nonsense consequence program with prosocial skill development to replace the power needs of the bully. In other words, consequences are uniform, predictable, and based on observed behavior of the bully; excuses and attempts to blame the victim for provoking the behavior are not listened to or tolerated. Behavioral consequences are swift and based on retribution or prosocial amends for the school community's benefit. The program does provide individualized intervention for bullies, which teaches the bullies how to monitor and correct their own thinking errors, manage anger better, and learn how to solve social problems.

4. Victims

Victims need support, protection, and a means to increase their social and interpersonal skills. Blaming themselves and believing that they are at fault leads to the sad-

194

ness and depression among these children (Byrne, 1994; Rigby, 1998). Creating a safe school environment helps them feel protected as they learn better social skills. Our program has individualized intervention for victims, which teaches victims friendship-making skills, understanding of self-esteem, and communication skills. Victims also get additional practice with the HA HA SO protective skills.

5. Parent Community

Parents feel secure when they know that their children are safe at school and that the staff will intervene when problems occur. Parents and students report higher frequencies of bullying than do teachers, and believe that the school often minimizes their concerns (Bonds & Stoker, 2000). The parent's responsibility is to know the difference between bully-victim problems and normal conflict in peer relationships. The parent's ability to assess the situation and intervene successfully brings greater support to the children who are victimized, which results in less anxiety and fear. The goal is to partner parents with the school in developing the program. *Bully-Proofing Your Child: A Parent's Guide* (Garrity et al., 2000) is an accompanying guide for parents to use as a school begins to implement this program.

Some schools tend to ignore the importance of the comprehensive nature of the Bully-Proofing program. They will pick and choose what to implement. Ultimately, these schools are disappointed because the overall culture of the school may not change (Arora, 1994). These schools typically focus on the bully and the victim alone. In our opinion, solutions to the problem of bullying require the involvement of the entire school community and simultaneous implementation of the five bully-proofing components described above. Through this comprehensive program, students learn to support a positive, caring atmosphere by seeing these behaviors modeled and rewarded by staff, parents, and peers.

Coming and Going to School (Supplemental Component)

A caring community stretches from home to school, yet many children do not feel safe on the school bus. In fact, for some children, it is the worst part of their day. The school bus poses unique problems. There is one driver with a job to do, which does not involve managing conflict or even being able to watch for problems. A group of children of different ages and grade levels rides together, yet may not see each other at any other time in their school day. The program for developing a caring bus community includes:

1. A breakfast for the drivers during which the bully-proofing program is explained.

2. Development of a comprehensive bus plan with (a) a plan for greeting the children and learning their names, (b) behavioral expectations on the bus, (c), behavioral warning forms, (d) seating charts, and (e) caring community nomination forms for caring behaviors on the bus.

3. A bus reward program. A system is established for tracking the behavioral warning forms and the caring community nomination forms from each bus. A reward program is established based on these behaviors. Rewards include special treats at lunch, homework passes, computer time, or school supplies.

Outcome Research

The Bully-Proofing Your School program was designed to reduce bullying behaviors in school and thereby increase students' sense of safety. The effectiveness of the program was measured at a suburban elementary school in Colorado over a four-year period (Epstein, Plog, & Porter, 1999). Students completed the Bully Survey, which is a 20-item questionnaire designed to assess the following characteristics of bullying: (a) physical bullying (e.g., hitting, kicking, or pushing); (b) verbal bullying (e.g., saying mean things); and (c) exclusion (e.g., encouraging others to leave someone out of play or social activity). In addition, students ranked their level of safety by location, including the classroom, playground, cafeteria, and going to and from school.

The Bully-Proofing program had a significant impact in decreasing all three types of bullying behaviors, but exclusionary behaviors took longer to impact than physical or verbal aggression (see Figure 5, on page 184). The students' sense of safety varied widely over the four-year period. Whereas a feeling of safety significantly increased on the playground as well as coming and going to school, no changes were noted in safety in the classroom (see Figure 6, on page 184). This finding may be due to the reasonably high levels of safety in this location before the Bully-Proofing program was implemented. The increased sense of safety in the locations without high adult presence may indicate the effective use of students sticking together as a caring majority.

Bullying Prevention Program

Olweus' (1993) Bullying Prevention program, which was developed in Norway, has been adopted in several countries. The most successful implementation of this program in the United States has been in South Carolina (Olweus & Limber, 1999), where it was selected as one of the "Blueprints for Violence Prevention" by the Center for the Study and Prevention of Violence at the University of Colorado. The criteria for selection are research evidence of program effectiveness.

The core elements of the Bullying Prevention program begin with the prerequisites of awareness of the extent of bullying and a commitment by the adults at a school to change the situation. At the school level, interventions include a bullying prevention committee, an anonymous survey, staff training, improved supervision, improved quality of the playground (availability of structures and equipment that encourage cooperative play), and a meeting with parents. Interventions encouraged for the classroom level include classroom rules against bullying, positive and negative consequences, classroom meetings, and classroom-level meetings with parents. Finally, the program

Figure 5

Percentage of students who reported they had experienced three types of bullying at five points in time.

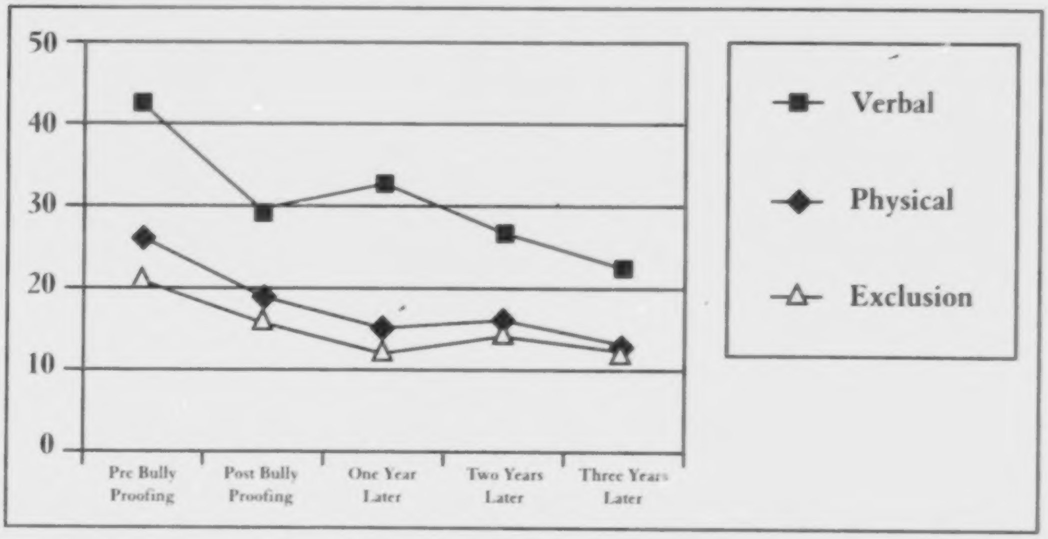
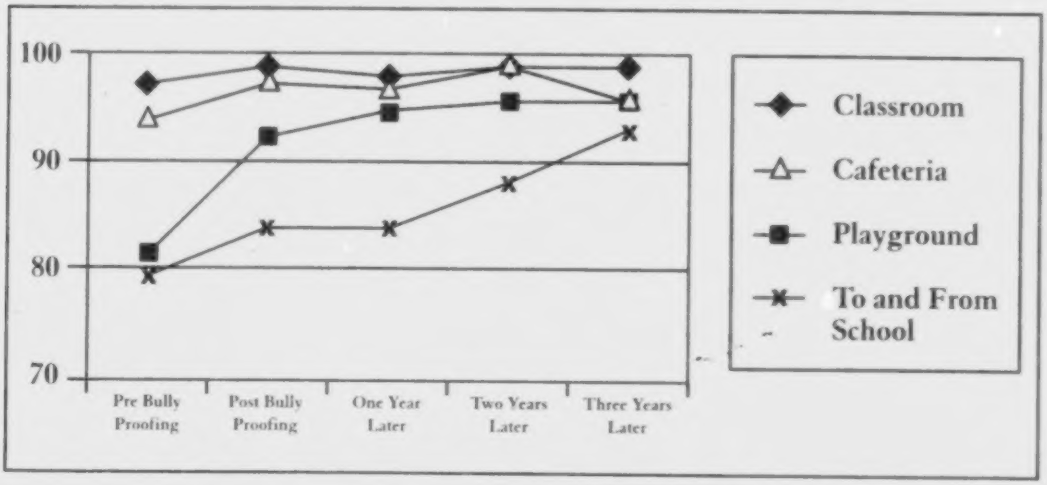


Figure 6

Percentage of students who felt safe in the classroom, cafeteria, on the playground, and going to and from school at five points in time.



includes interventions at an individual level such as serious talks with bullies, talks with victims, parent involvement, and having teachers and parents use their imagination. The South Carolina program also has a set of video clips, which are shown and discussed in the classroom meetings.

Bullyproof and Quit It

The Bullyproof and Quit It programs were developed by Nan Stein (1996) and colleagues at the Wellesley College Center for Research on Women. Their interest was in peer sexual harassment in adolescents and adults, and they felt certain that bullying was an antecedent to sexual harassment. The program consists of two teacher's guides on teasing and bullying. Quit It is for use with kindergarten through third-grade students; Bullyproof is for use with fourth- and fifth-grade students. The program is strong in developing academic skills, for example, webbing strategy for writing while teaching social skills. Bullyproof has 11 lessons, which can take 1 to 3 class sections each. The classroom activities include teacher-led discussions, student observations, role-plays, and writing assignments. Some of the lesson titles include "Teasing vs. Bullying," "Courage by Degrees," and "Letter to a Harasser or Bully."

No-Bullying Program

The No-Bullying program was developed for the St. Vrain Valley School District in Longmont, Colorado (Bitney & Title, 1996). This program also has two teacher's manuals, one for grades four and five, and one for grades six through eight. Each gives the teacher some developmental information about children in these grades, and then presents six lessons and accompanying teaching masters. The lessons emphasize classroom discussion and role-playing.

Bully Busters

The Bully Busters program (Newman, Horne, & Bartolomucci, 2000) was developed by a research group at the University of Georgia. The authors of the program describe two reasons for developing their teacher's manual. First, they believe that many schools do not have the time and money to do the comprehensive, schoolwide program recommended by Olweus (1993). Second, their research found that group counseling for bullies, victims, and even mixed groups of bullies and victims was ineffective in producing changes in bullying behavior. They thought working with a whole classroom might be more effective. Bully Busters is composed of seven modules of classroom activities, each taking three to four classroom sessions. The program is designed for upper elementary and middle school students. Modules include "Increasing Awareness of Bullying," "Recognizing the Bully," "Assisting Victims," and "Relaxation and Coping Skills." This curriculum involves the bystanders and works specifically to increase empathy through scenarios. The latter three programs (Bitney & Title, 1996; Newman et al., 2000; Stein, 1996) are curriculum-based, and none of the three describe any outcomes research that has been conducted.

Conclusion

No school or classroom is immune to bullying behavior. Bully-Proofing Your School was the first published and most comprehensive program in the United States. It promotes adult involvement, encourages a safe environment in which teachers can teach and students can learn, and, most important, creates a caring climate for all. The most valuable part of this comprehensive program is the involvement of the 85% of students who are neither bullies nor victims but who stand by helplessly as their classmates get beaten up emotionally and physically. They, too, have emotional scars from being silent witnesses and bystanders. Developing the intervention skills of these students into a caring majority, which sets a positive tone in the school, creates confidence and competence in life skills. Character grows when students take positive responsibility for themselves, their school, and their community. The caring majority is the most powerful weapon in creating a safe and caring school environment.

We have a huge knowledge base about what bullying is and what it does to victims, but in the United States, there is no empirical evidence of the effectiveness of these programs in peer review journals. Our study is, at best, a first step. Without a control group, attributions of causality cannot be made. Further, we do not know how changes in bullying and safety correspond to changes in academic and psychological functioning. Self-reports of bullying are said to be the best way to get information on measuring the impact on bullying.

The effectiveness of the bullying prevention programs reviewed here requires further research. Comparisons between curriculum-based programs and more comprehensive programs can be made. The research described here with the repeated student surveys demonstrates the effectiveness of the Bully-Proofing Your School program. However, future research needs experimental designs with random assignment of schools to establish a cause and effect relationship. Other dependent measures, such as discipline reports, school attendance, and achievement test score, are also needed.

References

Arora, C. M. J. (1994). Is there any point in trying to reduce bullying in secondary schools? A two year follow-up of a whole-school anti-bullying policy in one school. *Educational Psychology in Practice*, *10*, 155-162.

Arora, C. M. J., & Thompson, D. A. (1987). Defining bullying for a secondary school. *Educational and Child Psychology*, *4*, 110-120.

Baldry, A. C., & Farrington, D. P. (1998). Parenting influences on bullying and victimization. *Legal and Criminological Psychology*, *3*, 237-254.

Banks, R. (1997). *Bullying in schools*. (Report No. EDO-PS-97-17). Champaign, IL: Clearinghouse on Elementary and Early Childhood Education.

Barone, F. J. (1997, September). Bullying in school: It doesn't have to happen. *Phi Delta Kappan*, *78*, 80-83.

Batsche, G. M., & Knoff, H. M. (1994). Bullies and their victims: Understanding a pervasive problem in the schools. *School Psychology Review*, *23*, 165-174.

Bentley, K. M., & Li, A. K. F. (1995). Bully and victim problems in elementary school and students' beliefs about aggression. *Canadian Journal of School Psychology*, *11*, 153-165.

Berthold, K. A., & Hoover, J. H. (2000). Correlates of bullying and victimization among intermediate students in the Midwestern USA. *School Psychology International*, *21*, 65-78.

Bitney, J., & Title, B. B. (1996). *No-bullying program. Preventing bully and victim violence at school*. Minneapolis: Johnson Institute.

Bonds, M., & Stoker, S. (2000). *Bully proofing your school: A comprehensive approach for middle schools*. Longmont, CO: Sopris West.

Bosworth, K., Esplage, D. L., & Simon, T. R. (1999). Factors associated with bullying behavior in middle school students. *Journal of Early Adolescence*, *19*, 341-362.

Bower, A. (2001, March 19). Scorecard of hatred. *Time*, *157*, 30-31.

Byrne, B. J. (1994). Bullies and victims in a school setting with reference to some Dublin schools. *Irish Journal of Psychology*, *15*, 574-586.

Craig, W. M., & Pepler, D. J. (1995). Peer processes in bullying and victimization: An observational study. *Exceptionality Education Canada*, 5, 81-95.

Craig, W. M., Pepler, D., & Atlas. (2000). Observations of bullying in the playground and in the classroom. *School Psychology International*, *21*, 22-36.

Elliott, D. S. (Series Ed.). (1999). *Blueprints for violence prevention: Book nine, bullying prevention program*. Boulder, CO: Institute for Behavioral Science, Regents of the University of Colorado.

Epstein, L., Plog, A., & Porter, W. (1999). *Bully-proofing your school: Results of a four-year intervention*. Unpublished manuscript.

Flannery, D. J. (1999). Improving school violence prevention programs through meaningful evaluation. In E. Flaxman, (Ed.), *Choices in preventing youth violence* (No. 2, pp. 1-4). New York: Columbia University, Institute for Urban and Minority Education.

Garrity, C., Baris, M., & Porter, W. (2000). *Bully-proofing your child: A parent's guide*. Longmont, CO: Sopris West.

Garrity, C., Jens, K., Porter, W., Sager, N., & Short-Camilli, C. (2000). *Bully-proofing your school: A comprehensive approach for elementary schools* (2nd ed.). Longmont, CO: Sopris West.

Greenbaum, S., Turner, B., & Stephens, R. (1989). *Set straight on bullies*. Malibu, CA: Pepperdine University Press.

Greenfield, P. M., & Juvonen, J. (1999, July/August). A developmental look at Columbine. *APA Monitor*, p. 33.

Gutterman, N. B., & Cameron, M. (1997). Assessing the impact of community violence on children and youths. *Social Work, 42*, 495-505.

Hazler, R. J. (1996). Bystanders: An overlooked factor in peer-on-peer abuse. *Journal for the Professional Counselor, 11*, 11-21.

Hazler, R. J., Hoover, J. H., & Oliver, R. (1993). What do kids say about bullying? *Education Digest*, 58(7), 16-20.

Hoover, J. H., Oliver, R., & Hazler, R. J. (1992). Bullying: Perceptions of adolescent victims in the Midwestern USA. *School Psychology International, 13*, 5-16.

Hoover, J. H., Oliver, R., & Thompson, K. A. (1993). Perceived victimization by school bullies: New research and future direction. *Journal of Humanistic Education and Development, 32*, 76-84.

Kanan, L. M. (1998, May). *Exposure to violence: What all school providers need to know.* Paper presented to the Cherry Creek Mental Health Team, Denver, CO.

Madsen, K. C. (1996). Differing perceptions of bullying and their practical implications. *Educational and Child Psychology, 13*, 14-22.

Nash, I. (1989, October 20). True extent of bullying hidden. *Times Educational Supplement*, p. 5.

Newman, D. A., Horne, A. M., & Bartolomucci, C. L. (2000). *Bully busters. A teacher's manual for helping bullies, victims, and bystanders.* Champaign, IL: Research Press.

Olweus, D. (1978). *Aggression in the schools: Bullies and whipping boys.* Washington, DC: Hemisphere.

Olweus, D. (1991). Bully/victim problems among school children: Intervention and prevention. In D. J. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 411-448). Hillsdale, NJ: Erlbaum.

Olweus, D. (1992). Victimization by peers: Antecedents and long-term outcomes. In K. H. Rubin & J. B. Asendorf (Eds.), *Social withdrawal, inhibition, and shyness in childhood* (pp. 315-341). Hillsdale, NJ: Erlbaum.

Olweus, D. (1993). *Bullying at school: What we know and what we can do.* Oxford, UK: Blackwell Publishers.

Olweus, D., & Limber, S. P. (1999). Bullying prevention program. In D. S. Elliott (Series Ed.), *Blueprints for violence prevention: Book nine, bullying prevention program.* Boulder, CO: Institute of Behavioral Science, Regents of the University of Colorado.

O'Moore, M. (2000). Critical issues for teacher training to counter bullying and victimization in Ireland. *Aggressive Behavior, 26*, 99-111.

Ortega, R., & Lera, M. J. (2000). The Seville Anti-Bullying in School project. *Aggressive Behavior, 26*, 113-123.

Pepler, D. J., Craig, W. M., Ziegler, S., & Charach, A. (1994). An evaluation of an anti-bullying intervention in Toronto schools. *Canadian Journal of Community Mental Health, 13*, 95-110.

Rigby, K. (1996). *Bullying in schools and what to do about it*. London: Jessica Kinsley Publishers.

Rigby, K. (1998). The relationship between reported health and involvement in bully/victim problems among male and female secondary schoolchildren. *Journal of Health Psychology, 3*, 465-476.

Roland, E. (2000). Bullying in school: Three national innovations in Norwegian schools in 15 years. *Aggressive Behavior, 26*, 135-143.

Ross, D. (1996). *Childhood bullying and teasing: What school personnel, other professionals, and parents can do*. Alexandria, VA: American Counseling Association.

Samenow, S. (1989). *Before it's too late: Why some kids get into trouble and what parents can do about it*. New York: Random House.

Schwartz, W. (1999, Number 3). Developing social competence in children. *Choices briefs: Institute for Urban and Minority Education, Teachers College, Columbia University*, pp. 1-4.

Sharp, S. (1995). How much does bullying hurt? The effects of bullying on the personal well-being and educational progress of secondary age students. *Educational and Child Psychology, 12*, 81-88.

Smith, P. K., & Sharp, S. (Eds.). (1994). *School bullying: Insights and perspectives*. London: Routledge.

Stein, N. (1996). *Bullyproof. A teacher's guide on teasing and bullying for use with fourth and fifth grade students*. Wellesley, MA: Wellesley College Center for Research on Women.

Sullivan, K. (2000). *The anti-bullying handbook*. Auckland, NZ: Oxford University Press.

Twemlow, S., Sacco, F., & Williams, P. (1996, Summer). A clinical and interactionist perspective on the bully-victim-bystander relationship. *Bulletin of the Menninger Clinic, 60*, 296-313.

Endnote

[1] The "Humor" and "Own It" strategies that are used in the basic elementary curriculum were difficult for the younger children to understand and implement.

10

危
機

Peer Mediation and Conflict Resolution

Robert D. Myrick, Ph.D.
University of Florida

Peer mediation is already a popular helping process in many school districts and is emerging in others. While some interpersonal problems demand the attention of adults and professional counselors, in many instances young students, working as peer helpers, can be of valuable assistance. One way they help is through peer mediation, a process in which young people assist one another to talk about their situations, manage conflicts, resolve problems, and deter aggressive and violent behaviors (Johnson & Johnson, 1992; Schmidt, Friedman, & Marvel, 1992; Sorenson, 1992). Mediation is one form of conflict management that is receiving attention in schools across America. It involves a neutral third person, called a mediator, who assists two disputants in resolving their problem. The mediator is a facilitator rather than an arbitrator and guides the parties through a helping process (Beitel, 1997).

Conflict and Society

Conflict is inevitable. It springs from encounters with the environment and particularly from the human element when people come together. Not all conflict must end with an expression of violence, however, even though everyone is inclined to want his or her own way. There are peaceful solutions, in which conflict is managed and resolved, and these solutions are among the most valuable lessons that our nation's youths can learn (Myrick, 1997).

Concern about violence in schools has made the study of conflict and conflict management an urgent matter in education today (Sciacca, 1995). The public demands positive learning environments and safe schools for their children. Educators must find ways to help resolve conflicts among students and provide services that help young people who are prone to be aggressive and possibly violent. One approach is to use peer mediation (Powell, Muir-McClain, & Halasyaman, 1995).

The use of mediation to resolve disputes is a strategy that has been employed in business for many years. The approach is now being used more in schools and appears to produce favorable results. It can improve communication among students, teachers, administrators, and parents, and can enhance a school climate by addressing common issues and concerns of young people who are growing up in a world of conflict and violence (Myrick & Erney, 2000; Myrick & Folk, 1991; Zaragoza, Vaughn, & McIntosh, 1991).

Students Are Victims

Conflict and violence are not synonymous; however, unresolved and lingering conflict frequently leads to aggressive encounters that interfere with productivity in schools and communities. Although schools can be one of the safest places for our young people (Dwyer, Osher, & Warger, 1998), data from schools illustrate that instances of conflict and aggression, if left unchecked, can disrupt the learning environment and result in disciplinary problems. The following statistics highlight this point: (a) almost 300,000 high school students are attacked physically each month (National Center for Education Statistics, 1998); (b) about 20% of students in grades 9 through 12 carry some kind of weapon to school (National Center for Education Statistics, 1998); and (c) about 71% of children ages 7 to 10 worry they might get shot or stabbed at school or home (Harris, 1995).

These worries stem from public media reports and from what young people see and hear in their schools. For example, nearly 3 million thefts and violent crimes occur on or near school campuses every year. This crime level equates to almost 16,000 incidents per school day or one every 6 seconds, with 1.9 million of these incidents considered violent crimes such as rape, robbery, and assault (Snyder, Sickmund, & Poe-Yamagata, 1997).

The following are other crime-related statistics:

- 25% of eighth- and ninth-grade students have witnessed threats to teachers. (Elam, Rose, & Gallup, 1996).
- 70% of high school students say, "unruly students distract them and undermine classes" (National Center for Education Statistics, 1998).
- 41% of teachers feel that "violence in and around school" is "a serious problem" or "somewhat serious problem" (Elam et al., 1996).
- Over a 2-year period, 105 school-associated violent deaths occurred; 77% of these deaths involved firearms (Kachur, 1996). In 1995, 14% of "violent crimes" in the nation occurred "at a school" (Chandler, Chapman, Rand, & Taylor, 1998). Since these reports, some of the most violent tragedies in the history of our nation's schools have taken place.
- 12% of sixth- through twelfth-grade students reported they were victims of physical attack, robbery, or bullying in school. (Heaviside, Rowand, Williams, & Farris, 1998).

- According to a survey of educators at a National Association of Secondary School Principals convention, 61% have had to confiscate at least one firearm; 50% require police intervention daily, weekly, or monthly for violent acts occurring in their schools (National Association of Secondary School Principals, 1997).

- 40% of secondary school teachers think that physical conflicts among students are a problem (Kingery, Coggeshall, & Alford, 1998).

- Approximately 10% of students in kindergarten through twelfth grade experience an attack by schoolmates on a regular basis. These assaults include verbal aggression (e.g., name-calling, threats of physical harm, extortion) and physical aggression (e.g., hitting, slapping, robbery, and threats with guns and knives) (Kingery et al., 1998).

- Although shootings in schools have elevated concerns about firearms on school campuses, knives and razors are the weapons most likely to be carried by students (Kann et al., 1996).

- While 42% of students nationally say they rarely see violence in or around their school, 41% report seeing violence sometimes, and 9% say they see violence very often in or around their school (Harris, 1996).

- Nationwide, 4% of students had missed 1 or more days of school during the 30 days preceding the survey because they had felt unsafe at school or when traveling to or from school. Approximately one-third (32.9%) of students nationwide had had property (car, clothing, or books) stolen or deliberately damaged on school property one or more times during the 12 months preceding the survey (Synder et al., 1997).

- Recent trends, however, suggest that the rates of school crime committed by youths have steadily declined since they reached a peak in the early 1990s (Snyder & Sickmund, 1999).

Teachers Are Victims

Students are not the only victims of violence in school. Although the majority of teachers believe that they are unlikely victims in and around school, teachers claim that discipline is the main reason they leave the profession (Elam et al., 1996). Moreover, students perceive that more violence is occurring in schools than do their teachers (Kaufman et al., 1998). Many teachers, especially those in urban areas, do not feel safe after school hours. Women and younger, less experienced teachers are targets, but they are not the primary victims of violence among school staff. Rather, teachers who are considered to be strict and who insist that students adhere to rigorous academic and behavioral standards are most at risk of being victimized. For instance, 38% of teachers and 57% of students rank strict teachers as more at risk of victimization than any other members of the teaching staff (Harris, 1996).

A growing concern is that, if teachers fear that they will be targets of students' physical or verbal abuse, they will be less willing to insist that all students meet new, more rigorous standards. In addition, teachers will be unwilling to intervene in certain situations, especially in altercations between students. Many teachers are concerned about being victimized. They worry about being sued or wrongly accused if they intercede in student fights or acts of violence. In addition, not enough teachers and counselors are in the schools to always be present when a conflict must be resolved.

Responses to School Conflict and Violence

Most governmental and school authorities have responded by employing strategies that involve more rules, policies, procedures, and security devices. But the purchase of walk-through detectors and hand-held metal detectors that can be used in body searches is an expensive venture. When funds are available, schools also have purchased conflict management curriculum materials and employed more counselors, school psychologists, security officers, and teachers to work in special prevention programs.

Some school districts are requiring students to wear school uniforms and are helping pay the costs for those who cannot afford them. Workshops and seminars are used to provide additional training in drug and crime prevention to teachers. In some cases, schools are being kept open longer, and more personnel have been hired to supervise students in after-school care.

Most school systems deal with conflict through such traditional approaches as discipline referrals to the principal's office and parent conferences. These reactive and punitive approaches typically penalize students by restricting participation in school activities, requiring after-school detention, utilizing in or out of school suspension, perhaps even expulsion, or relying on juvenile court hearings (Bowditch, 1993).

The assumption is that uncomfortable consequences will increase awareness of socially inappropriate behavior and, subsequently, deter conflict and related problems. Authorities, however, cannot be sure that the "punitive" consequences are aversive to aggressive students, who often seek attention and prefer to be seen as "tough and uncaring" rather than "stupid and compliant."

Even if there were evidence that punitive measures are effective in limiting violent acts in schools, such measures do not address the causes of violence and often serve only to move the violence elsewhere in the community. These methods do not appear to teach students the problem-solving and conflict-resolution skills they need to live in a productive, nonviolent way.

Dissatisfaction with traditional processes used to settle disputes has led school administrators and counselors to try new ways of conflict resolution. One such promising intervention is the use of peer helpers in developmental guidance activities and in such roles as peer mediators (Schrumpf, Crawford, & Bodine, 1997; Trevaskis, 1994).

Peer Mediation and Change

There is growing consensus that the best way to handle violence in the schools and prevent its spread throughout the community is to defuse disputes before they turn violent (Furtwengler, 1996). In some cases, this means helping students learn to cope with educational practices that can produce conflicts (Hyman & Perone, 1998). Traditional school environments and curricula do not fit every student. Those who find schools too restrictive, conforming, authoritarian, and routine will often find themselves in conflict with their teachers and other students.

Peer mediation is a form of counseling or consulting in which students with disputes are involved in a problem-solving process. They talk to each other face to face in a safe and supportive discussion, which is led by a trained peer facilitator or mediator. The process is organized, structured, systematic, and aimed at producing some kind of positive action. The goal is to reduce conflict through negotiation and collaboration.

The mediators set the ground rules or guidelines. Although it is possible for one peer mediator to lead a meeting, typically two peer mediators are present whenever possible. This usually has a settling or calming effect on everyone in the room and diminishes the perception that the mediators are teaming against one of the participants. Mediators, in this case, take turns leading the disputants through each stage or step of the resolution process (Kreidler, 1994; Lane & McWhirter, 1992; Schmidt et al., 1992).

Everyone listens while each disputant gives his or her explanations or ideas and expresses their feelings in a nonaggressive way. The mediator's role is primarily to restate or summarize the information provided, ask questions, clarify issues, respond to feelings, and guide the parties through an organized process. Eventually, an agreement is reached in which both parties know what is expected of them and what actions they must take. This agreement becomes a written contract that is signed by everyone in the room.

People tend to resist change when they believe that it is imposed on them or when they have little responsibility for bringing it about. In my experience, people tend to accept change when they: (a) actively participate in the decision to change; (b) help design a change; (c) are convinced that rewards for change exceed the pain of change; (d) see others changing; (e) sense that the environment is free from threat and judgment; (f) possess, or can acquire, the knowledge or skills required by the change; (g) trust the motives of the person(s) attempting to bring about change; and (h) are equally able to influence the person who is attempting to influence them.

Mediation is about helping people change. It is usually a negotiation process in which each party looks for respect. Both parties want to leave feeling that they were heard and understood and that they gained something.

It has taken a while for adults to recognize that young people are competent and able to take an active role in resolving disputes and reducing conflicts. Peer mediation in schools shifts more responsibility to young people to solve conflicts. While it involves adult supervision, adults have more time to concentrate on creating a positive learning environment. It frees adults to focus more on teaching, consulting, and building friendly working relationships rather than on administering discipline. Research suggests that peer mediation in schools can reduce violence, vandalism, absenteeism, suspensions, and punitive actions in discipline cases (Goldsmith & Reynolds, 1997; Myrick, 1992; Myrick, Highland, & Sabella, 1995; Silver, Coupey, Bauman, Doctors, & Boeck, 1992).

Peer mediation provides a means of problem solving that is suited to the nature of young people's problems. As students grow older, they want to take more responsibility for their lives and be less dependent on their parents. When students have problems, they frequently turn to their peers for assistance rather than to parents or other adults, especially at first (Colucci, 1993; Ferrara, 1997).

Training Peer Mediators

The best peer-mediation programs feature training sessions and activities through which young people learn how to be mediators. Some programs are more comprehensive than are others (e.g. Myrick & Folk, 1991; Tindall, 1995) and enable students to be involved in various situations, working individually or in groups. Other training programs are more limited and focus on specific concepts, skills, and a structured mediation process (Boehm, 1991; Garcia-Vasquez & Ehly, 1992; Powell et al., 1995; Tobias & Myrick, 1999).

Peer mediators are typically trained to have some knowledge about interpersonal relationships, be attentive listeners, and be able to facilitate others in a discussion. They examine the way people tend to solve conflicts and apply problem-solving methods. Most often trainers outline a step-by-step decision-making process for peer mediators to use as a foundation for mediation (Myrick & Erney, 2000).

The process of collaboration is taught as part of peer mediation training because it is considered the most satisfactory way to resolve conflict. The "collaboration style" typically requires more time to think through possible actions. It takes time to explore alternatives, identify the issues, determine the possible consequences, and process how it will affect relationships. Collaboration is at the heart of the peer-mediation process.

In most cases during school, time is short and the parties want to resolve the dispute quickly. A structured problem-solving process tends to work best because it can provide subtle control of the situation, ensuring that each party is given equal treatment and an opportunity to participate in finding a satisfactory solution (Myrick, 1997).

There are many problem-solving models, each with specific steps that can be modified to suit a particular school or program. In my experience, it works best when all peer mediators in a school program follow the same basic mediation steps. The processes of peer mediation can spread beyond the confines of the room where a dispute is being resolved. The peer-mediation approach also provides valuable experience and familiarity with conflict-management strategies and makes it easier to monitor and supervise students (Myrick, 1992; Sorenson, 1992).

Supervising Peer Mediators

It is not enough to simply train students to be peer mediators; they also need supervision. Peer helpers are limited in their work and are not going to replace school counselors or other professional services. Peer mediators need an opportunity to talk about the helping process and how to improve their work. They need timely support and reassurance. If a situation is too tense and difficult, then peers can refer the case to their supervisor.

Lewis and Lewis (1996) surveyed schools in the state of Washington and learned that many schools used peer counselor programs, but noncounseling professionals supervised a significant number of such programs. Furthermore, they found that these supervisors were less effective than those who were certified counselors, particularly as related to the prevention of violence and suicide.

Facilitative Skills

Peer mediation can take place at all grade levels (Foster-Harrison, 1995). To train younger students, more structured learning activities and interventions are required and fewer skills are taught, learned, and managed in the helping process (Bowman & Bowman, 1997; Bryant, 1992; Johnson, 1995; Myrick & Bowman, 1981). In general, all mediators learn to make feeling-focused responses and give attention to the pleasant and unpleasant feelings a person may be experiencing. Clarifying and summarizing statements help focus attention on the events in a situation. Open-ended questions, especially those that begin with "what" or "how," are recommended because they encourage the parties to be specific while giving them a chance to tell their stories. Older students can learn to reframe ideas and to apply other more sophisticated verbal skills, many of which are commonly used in counseling, that provide additional comfort, understanding, insights, and mutual agreements (Myrick & Erney, 2000).

A facilitative style or model is advocated (Morey, Miller, Rose, & Fulton, 1993). Some responses are viewed as low-facilitative and are used only with caution or avoided entirely, including interpretation and analysis of behavior, reassurance, and advice. Mediators are encouraged to increase the use of high-facilitative responses in their work, including feeling-focused responses, clarifying and summarizing statements, and opened-ended questions (Myrick & Erney, 2000).

Getting Started

For the process to work, at least one party who is part of the conflict must be willing to initiate contact with someone in the peer-mediation program. On occasion, one or more parties can be referred by a friend or concerned adult. At this point, individuals are seen and the general process is explained to one or both disputants. They are asked to follow the school or program procedures to arrange a meeting with peer mediators and agree to participate in the process. Both disputants must agree to take part.

A Step-by-Step Model for Peer Mediation

Peer mediators can follow a step-by-step model or a list of the mediation stages and guidelines. A simple outline includes a few ideas for the mediators and parties to keep in mind as they proceed through the process. In general, time is allowed for introductions, an explanation of ground rules, and then listening to the explanations of the participants, identifying desired outcomes, brainstorming possible solutions, finding some common interests and goals, and settling on a plan of action. These ideas are found in almost all problem-solving models.

It is common to have more than one peer mediator present when helping parties resolve their conflicts, although one mediator could implement the steps. A Seven-Step Model for Peer Mediation is outlined in Table 1. In each step the peer mediators are instructed to follow simple rules and procedures.

Table 1

A Seven-Step Model for Peer Mediation

Step 1. Make Introductions.

Find a safe and private location for sharing information. Form a triangle with one party involved in the dispute seated to your right and the other to the left, which provides a neutral space. This allows you to direct the process more easily. For example, the two disputants might be seated at the end of a table, with you and, perhaps, another mediator in the middle. Everyone remains seated during the meeting and there is no physical contact or verbal abuse.

Now, introduce yourself and ask the disputants to state their names. Names are important and used often in the process. When making introductions, the mediators help set the tone through their friendly and courteous behaviors. Even though the parties may know one another, the introductions help slow the pace of the process and everyone's voice is heard at the beginning.

Make an opening statement that outlines the process, emphasizing that each person will get a chance to talk about the events while the other listens. Being a careful listener is essential to helping find a solution to the problem. Say that you understand that there is a conflict between the students and that you are offering mediation as an opportunity to solve the conflict without disciplinary action or parental involvement.

Use all the high-facilitative responses to help set the stage for mediating a conflict between two people. While it is important to listen and encourage people to talk, it is also essential that limits be set in order for the parties stay on task.

Step 2. Explain Ground Rules.

Explain that a few simple guidelines or ground rules have proven helpful in the mediation process. Point to a list, which appears on a piece of paper or posterboard. These are clarified as needed and everyone agrees to: (a) be respectful and avoid name-calling or put downs, (b) listen carefully and don't interrupt when others are talking, (c) agree to follow the ground rules for mediation, (d) work toward a solution, and (e) take some positive action.

Step 3. Hear the Story.

Decide who will go first by mutual agreement or by a flip of a coin. A mediator could say, "Since Person #1 contacted us first, is it OK if he/she goes first?" If one disputant seems more eager to begin and it's OK with the other, the eager one starts. Find some way for them to agree on who goes first.

Mediators listen carefully to what each person has to say about what happened. Begin by asking Person #1 for the story, from his/her point of view. One of the mediators repeats what was heard, using feeling-focused, clarifying, and summarizing responses. Try not to ask too many questions. Ask for any corrections or modifications from the speaker regarding summarizing and clarifying remarks.

Encourage each person to tell his/her side of the conflict, starting at "the beginning," as completely as possible. While the first person talks about the events, the second person is encouraged to listen attentively and without interruption. Assure everyone that they will get a turn to be heard without interruption.

When the first speaker finishes, thank him/her and ask if there is anything else. Repeat briefly what was heard. Next, turn to and thank the other person for being a patient listener.

Now, invite the second person to begin speaking. On some occasions the mediators can ask the second party to summarize what the first person said, perhaps helping identify any feelings that were expressed. This particular facilitative gesture, however, must be used with caution. Staying on task at this step is important. Otherwise, the story telling could switch to the second person before it is his or her turn. In addition, the mediators have less control when they turn to the second party to check if he/she is listening.

Step 4. Find Desired Outcomes.

After each person has talked about the events, ask each to describe what he/she would like to see happen. Using facilitative responses, some areas of agreement, common feelings and interests, and similar goals are found.

Table 1 continued p. 200

BEST COPY AVAILABLE

Table 1 continued

Now that initial statements have been heard, this is probably a good time to relax the "do not interrupt" or "speak only when it is your turn" rule. In this step, discussion becomes a little more free-flowing. If the discussion becomes too one-sided or unpleasant, then the "one at a time" rule can be used again.

If several desired outcomes are named, participants narrow their wishes to one or two of the most important ones that could help resolve the conflict. This step focuses the problem and goal(s), which leads to a plan of action. The use of high-facilitative responses to discover what each person wants to have happen is suggested in order to make the next step productive.

Step 5. Search for Options and Solutions.

The disputants are asked to think of possible solutions and to describe how the conflict might be resolved and avoided in the future. Sometimes it is helpful to brainstorm as many solutions as possible, with the assumption that creative ideas can become more specific, practical, and mutually satisfying. This is a time for nonjudgmental efforts and to be open to exploring ideas.

Some solutions may have already surfaced as "needs" or ""wishes" during the steps above. A skilled mediator makes note of them and checks them out by asking if they might be true or workable. If there are no obvious solutions, each party is asked: "What do you want things to be like?" Then, "What would it take for you to help make that happen?"

If nothing emerges at this point, some more work on what the conflict is about is probably needed. Participants look for hidden agendas, hurt feelings, or both. If resistance is high, then the process is started again, making sure that each person shares their feelings as well as what they think would make things better.

Mediators list the ideas. After everyone has contributed, each idea is discussed. Consensus is one objective. Ideas might be rated in terms of a five-point scale or rank-ordered from most to least favored. The parties talk about possible consequences and how acceptable it is to everyone.

Step 6. Choose a Solution.

The process is summarized and each party is asked to describe one or more solutions that make sense and can be agreed upon. Clarifications are made. Both parties are encouraged to ask questions about the best idea that seems to be emerging. Mediators usually ask how the problem can be avoided in the future and clarify what each must do to prevent a conflict from happening.

Sometimes mediators cannot get disputants to agree, especially if one or both are unwilling to listen, compromise, or be respectful of others' wishes. Sometimes resistance runs high if there is a feeling that one is losing face or is gaining nothing. A person may get more pleasure from continuing to direct his/her frustration and anger at the other person, getting some personal pleasure from continued conflict. The final solution may be an agreement to "stay away from each other," and that may be the best you can do at the time. These cases are rare, because the vast majority of students will want to find a satisfactory solution that can make things better for themselves and others.

If the parties agree that one particular solution is acceptable, they resolve to follow the plan. It is important that each party voices approval of the plan. A written agreement on a standard form can outline the solution. The mediator, as well as both disputants, signs and dates it. Everyone receives a copy. This formal agreement bolsters commitment and later can be reviewed and evaluated.

Step 7. Close the Meeting.

The parties are reminded that the matter is personal and private. While some mediators choose to use the word confidential, it is difficult to guarantee it. When others ask about the problem or what happened, nothing more needs to be said than that it has been solved.

If necessary, arrangements are made for a brief follow-up to help review progress or evaluate the solution. This may be particularly helpful if additional steps are needed after beginning with a few small ones. If requested, the process can be repeated if either party fails to live up to the agreement. The meeting ends on a friendly note. It is concluded that a disagreement is an opportunity to make things better and easier for everyone. The parties are then congratulated for their willingness to work together to find a solution and then the meeting is adjourned.

Facilitator, Not a Counselor

Peer mediators are taught to recognize their limits—they are not professional counselors or therapists. The title "peer counselor" is an unfortunate one and has been credited with communicating an inappropriate message about peer helpers (Myrick & Erney, 2000).

Mediators help the individuals in conflict communicate more clearly with each other. Mediators help define the issues in the conflict and guide the discussion of those issues. They also help the disputants explore options and make informed decisions about solving their problems.

Mediators don't make the decisions or force solutions on anyone. The disputants determine how to resolve their conflicts. In my experience, agreements are reached in approximately 85% of mediations. Participants are more likely to live up to a decision they made themselves than to one that others made for them.

Another mediation process follows a four-stage model, which includes 16 steps. This model (see Table 2) is placed in front of the mediators and the disputants who agreed to be present. All parties are told that the outline will be followed in order to be as fair as possible and to give everyone a chance to be a part of the mediation process.

Table 2

A Four-Stage Peer Mediation Model

Stage I. Introduction

1. Introduce yourselves as mediators.
2. Ask the disputants if they would like your help in solving the problem.
3. Find a quiet area to hold the mediation.
4. Ask for agreement to the following:
    a. try to solve the problem
    b. be positive and avoid name-calling or put downs
    c. let the other person finish talking
    d. respect privacy and confidentiality

Stage II. Listening

5. Ask the first person "What happened?" Summarize.
6. Ask the first person how she or he feels. Reflect the feelings.
7. Ask the second person "What happened?" Summarize.
8. Ask the second person how she or he feels. Reflect the feelings.

Stage III. Looking for Solutions

9. Ask the first person what she or he could have done differently. Summarize and reflect the feelings.
10. Ask the second person what she or he could have done differently. Summarize and reflect the feelings.
11. Ask the first person what she or he can do here and now to help solve the problem. Summarize and reflect the feelings.
12. Ask the second person what she or he can do here and now to help solve the problem. Summarize and reflect the feelings.
13. Use what and how questions to bring disputants closer to a solution.

Stage IV. Finding Solutions

14. Help both disputants find a solution they feel satisfied about.
15. Repeat the solution and all of its parts to both disputants and ask if each agrees to the actions to be taken.
16. Congratulate both people on a successful mediation.

214

BEST COPY AVAILABLE

Objectives of Peer-Mediation Programs

The underlying and primary objectives of peer mediation are to: (a) increase student understanding that conflict is a natural and normal part of life, (b) enable students to work in harmony with each other despite differences, (c) create a positive school climate using a process to resolve interpersonal conflict, (d) avoid suspensions and expulsions from school by providing alternative methods of dealing with misbehavior, (e) increase attendance and academic performance by decreasing the environment of conflict and violence, and (f) develop an awareness and encourage the use of compromise as a viable alternative to conflict and to relate this to a deeper understanding of the American political system.

The training programs appeal to young people (Vanayan, 1997) because they like learning how to communicate and work with others. In understanding conflict, peer helpers also gain control, self-respect, and confidence, all of which are skills that can empower them throughout their lives.

An Ounce of Prevention

Teaching young students the general concepts of conflict resolution in advance of a crisis is another method to help reduce school violence. Children, for instance, can be taught ways to deal constructively with conflict. Through small and large group discussions, peer helpers can demonstrate how to; (a) disagree fairly; (b) say clearly what one wants; (c), listen carefully to what another person is saying; (d) express feelings, (e) understand how another person feels; (f) speak up and take a stand for one's rights; (g) respect the rights of others; (h) control impulsive behavior; (i) share, take turns, compromise, and solve problems; and (j) accept responsibility for their behavior.

In this preventive approach, conflict resolution is integrated into the school curriculum. Examples are studied and applied as part of regular classroom instruction. For example, a discussion of how conflicts are solved in business, among nations, and with special interest groups might lead to a more personalized discussion in which students talk about how the issues and possible solutions might be a part of their community and school.

While a teacher or counselor might lead a discussion, peer helpers can play valuable roles through role-playing and by working as small group leaders (Tindall, 1995). Sometimes a "class meeting" is held. Students sit in a circle, perhaps on the floor, which creates a sense of sharing and equality. All participants can see one another. The general guidelines for mediations are followed, such as everyone gets a turn to speak and there are no interruptions or negative comments. Everyone listens carefully before the group attempts to reach an agreement or make a decision (Wittmer, Thompson, & Sheperis, 1999). It might be described as a time for "caring and sharing" (Myrick & Erney, 2000).

Peer Facilitator and Mediator Effectiveness

Huey and Rank (1984) were among the first to provide evidence that peer facilitators can effectively reduce aggressive behavior. Using pre- and postmeasures, and comparisons with control groups, their results suggested that professional counselors and peer facilitators were equally effective in teaching skills and in reducing aggressive classroom behavior among adolescent boys. In addition, subjects in the study were equally satisfied with peer or professional counselors as group leaders.

A meta-analysis by Tobler (1986) examined 143 adolescent drug-prevention programs. She concluded that peer programs are dramatically more effective than all other types of interventions, in both rural and inner city areas.

One study (Tobias & Myrick, 1999) examined the effects of an eighth-grade peer facilitator intervention with sixth-grade problem-behavior students. A comparison of experimental and control groups from three middle schools (N = 150) indicated a significant difference between groups. A repeated-measures analysis of covariance was used with pre- and postdata on six dependent variables. Results favored the peer intervention in terms of school attendance, school grades, discipline referrals, and attitude toward school. Attitude toward others and self-concept were also investigated. The intervention consisted of two parts: a peer-led small group guidance unit combined with peer-led individuals sessions over a six-week grading period.

The Conflict Resolution/Peer Mediation Project (CR/PM) included three socioeconomically and racially diverse middle schools in North Central Florida (1995-1999). The project focused on reducing the level of chronic disruptive and aggressive behavior in middle school populations through increased knowledge of conflict-resolution skills, including peer mediation. Each school selected cohorts of 25-30 students to serve as peer mediators each year; students were trained in a two-day workshop that focused on communication skills and mediation techniques. From fall 1996 through spring 1999, a representative sample of 85 students served as peer mediators, mediating a total of 195 conflicts. The issue in 84% of referred conflicts was verbal harassment; disputants mentioned gossip (36%) and physical aggression (19%). In more than 95% of referred conflicts, disputants reached an agreement, usually consisting of avoiding each other (44%) or stopping the offending behavior (39%). There was a high degree of satisfaction with the process by disputants, mediators, parents, and teachers.

An examination of peer-mediation projects in Florida, North Carolina, Maryland, and Missouri resulted in evidence of attitude modification about violent behavior, improved school discipline, and reduced absenteeism. For example, the suspension rate was soaring at a middle school when the administration began a peer-mediation/conflict-resolution program. The program resulted in a drop of 18.5% in the suspension rate and a 92% approval rating by teachers (Thompson, 1996).

Johnson, Johnson, & Dudley (1992) noted that the objective of one peer-mediation program was to lower the number of school conflicts referred to the school administration for resolution. The mediation training appeared effective in helping peer mediators reduces the number of teacher referrals.

A developmental guidance unit entitled "Confronting Sexual Harassment" was implemented in two middle schools with the help of high school peer facilitators. It consisted of eight sessions, with age-appropriate activities that taught students how to cope with and prevent harassment. Peer-led discussion groups, as well as timely confrontations assisted by peer helpers, proved more effective than other interventions (Sabella & Myrick, 1995).

Lane and McWhirter (1992) described a conflict-management program that used elementary and middle school students as peer mediators who worked as a team to encourage problem solving on the playgrounds and in lunchrooms. In the first stage, mediators separated the disputants, introduced themselves, and reviewed mediation rules with them. Talks continued until a solution was mutually acceptable. The program helped reduce the number of discipline referrals to the school administration and the number of conflicts reported in school.

In some instances, aggressive and disruptive students are recruited and trained as peer mediators. The process of training becomes "treatment," as the mediator's own behavior improves (Myrick & Folk, 1991; Silver et al., 1992). When troublesome students are placed in a role of responsibility, their image can change. In one study, teenagers rated as "disliked" by their peers were paired with those who were rated as "well liked." The "disliked" students worked as tutors. The results showed that students paired in this manner were seen as more socially accepted by their age mates at the end of the study than were those in a control group. An increase in social acceptance increased if the "disliked" student served as a tutor (Mathur & Rutherford, 1991).

When 138 elementary and middle school students were surveyed and asked about the help received from peer facilitators, they clearly indicated that the assistance was valuable. Approximately 90% of the students at both grade levels looked forward to meeting with their peer helper and more than half spoke positively about the experience with their classmates (Myrick et al., 1995).

The Value of Peer Mediation

The primary reasons for having a peer-mediation and conflict-resolution program in any school are that it is practical, feasible, inexpensive, and effective. The results are often equally as successful as those obtained by adults. This approach saves school personnel from becoming involved in the minutiae of day-to-day adolescent problems and frees them to deal with more serious issues and use their time more effectively.

When students help in solving problems in a school setting, it also enables professional counselors and teachers to use their time more effectively and efficiently. It makes sense that kids solve "kid problems" and that adults be brought into the picture only when the problems warrant adult intervention. Peer helpers, working as facilitators and mediators, can play a powerful role in conflict resolution and in creating safe and productive school climates.

References

Beitel, M. (1997). Nuances before dinner: Exploring relationships between peer counselors and delinquent adolescents. *Adolescence, 32*, 213-217.

Boehm, K. (1991). Teen Line: A descriptive analysis of a peer telephone listening service. *Adolescence*, 26, 643-48.

Bowditch, C. (1993). Getting rid of troublemakers: High school disciplinary procedures and the production of dropouts. *Social Problems*, 40, 493-507.

Bowman, R. P., & Bowman, S. (1997). *Co-Piloting*. Chapin, South Carolina: Youth Light, Inc.

Bryant, K. B. (1992). Conflict resolution strategies in relation to children's peer relations. *Journal of Applied Developmental Psychology*, 13, 35-50.

Chandler, K. A., Chapman, C. D., Rand, M. R., & Taylor, B. M. (1998). *Students' reports of school crime: 1989 and 1995*. Washington, DC: U.S. Departments of Education and Justice. NCES 98-241/NCJ-169607.

Colucci, S. (1993, May). Peer mediation: Creating opportunities for conflict resolution. NASP *Communiqué*, 3, 25-27.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U. S. Department of Education.

Elam, S. M., Rose, L. C., & Gallup, A. M. (1996). 28th annual Phi Delta Kappa/Gallup poll of the public's attitudes toward the public schools. *Phi Delta Kappan*, 78, 41-59.

Ferrara, J. M. (1997). *Peer mediation: Finding a way to care*. New York: Stenhouse.

Furtwengler, W. J. (1996). Improving secondary school discipline by involving students in the process. *NASSP Bulletin*, 80, 36-44.

Foster-Harrison, E. (1995). Peer helping in the elementary and middle grades: A developmental prospective. *Elementary School Guidance and Counseling*, 30, 94-103.

Garcia-Vasquez, E., & Ehly, S. W. (1992). Peer tutoring effects on students who are perceived as not socially accepted. *Psychology in the Schools*, 29, 256-265.

Goldsmith, M., & Reynolds, S. T. (1997). *Peer health education programs*. Santa Cruz, CA: ETR Associates.

Harris, L. (1995). *The Metropolitan Life survey of the American teacher: Between hope and fear*. New York: Louis Harris Associates.

Harris, L. (1996). *The Metropolitan Life survey of the American teacher: Students voice their opinions on violence, social tension and equality among teens*. New York: Louis Harris Associates.

Heaviside, S., Rowand, C., Williams, C., & Farris, E., (1998). *Violence and discipline problems in U.S. public schools, 1996-97*. Washington, DC: National Center for Education Statistics.

Huey, W. C., & Rank, R. C. (1984). Effects of counselor and peer-led group assertive training on black adolescent aggression. *Journal of Counseling Psychology*, 31, 95-98.

Hyman, I. A., & Perone, D. C. (1998). The other side of school violence: Educator policies and practices that may contribute to student misbehavior. *Journal of School Psychology*, 30, 7-27.

Johnson, D. W. (1995). Training elementary school students to manage conflict. *Journal of Social Psychology*, *135*, 673-686.

Johnson, D. W., & Johnson, R. (1992). Conflict resolution and peer mediation programs in elementary and secondary schools: A review of the research. *Review of Educational Research*, 66, 459-506.

Johnson, D. W., Johnson, R. T., & Dudley, B. (1992). Effects of peer mediation training on elementary school students. *Mediation Quarterly*, *10*, 89-99.

Kann, L., Warren, C. W., Harris, W. A., Collins, J. L., Douglas, K. A., Collins, M. E., Williams, B. I., Ross, J. G., & Kolbe, L. J. (1996). Youth risk behavior surveillance – United States, 1995. *Morbidity and Mortality Weekly Report*, *45(SS-4)*, 1-83.

Kachur, S. P. (1996). School-associated violent deaths in the United States, 1992 to 1994. *Journal of the American Medical Association 275*, 1729-1733.

Kaufman, P., Chen, S. P., Choy, K. A., Chandler, C. D., Chapman, C. D., Rand, M. R., & Ringel, C. (1998). *Indicators of school crime and safety, 1998*. Washington, DC: U.S. Departments of Education and Justice. NCES 98-251/NCJ-172215.

Kingery, P. M., Coggeshall, M. B., & Alford, A. A. (1998). Violence at school: Recent evidence from four national surveys. *Psychology in the Schools*, *35*, 247-258.

Kreidler, W. J. (1994). *Conflict resolution in the middle school*. Cambridge, MA: Educators for Social Responsibility.

Lane, P. S., &, McWhirter, J. J. (1992). A peer mediation model: Conflict resolution for elementary and middle school children. *Elementary School Guidance and Counseling*, *27*, 15-24.

Lewis, M., & Lewis, A. (1996). Peer helping programs: Helper role, supervisor training, and suicidal behavior. *Journal of Counseling and Development*, *74*, 307-313.

Mathur, S. R., & Rutherford, R. D. (1991). Peer-mediated interventions promoting social skills of children and youth with behavioral disorders. *Education and Treatment of Children*, *14*, 227-242.

Morey, R., Miller, C., Rose,, N. L., & Fulton, R. (1993). High school peer counseling: The relationship between student satisfaction and peer counselors' style of helping. *The School Counselor*, *40*, 293-299.

Myrick, R. (1992). Peer helpers: The helping hands of school counselors. *The Peer Facilitator Quarterly*, *10*, 6-8.

Myrick, R. D. (1997). *Developmental Guidance & Counseling*. Minneapolis, MN: Educational Media Corporation.

Myrick, R. D., & Bowman, R. P. (1981). *Children helping children: Teaching students to become friendly helpers*. Minneapolis, MN: Educational Media Corporation.

Myrick, R. D., & Erney, T. (2000). *Caring and sharing*. Minneapolis, MN: Educational Media Corporation.

Myrick, R. D., & Folk, B. (1991). *Peervention*. Minneapolis, MN: Educational Media Corporation.

Myrick, R., Highland, W., & Sabella, R. (1995). Peer helpers and perceived effectiveness. *Elementary School Guidance and Counseling*, *29*, 278-288.

National Association of Secondary School Principals. (1997). *Safety issues serious in nation's schools: Principals taking action*. Reston, VA: Author.

National Center for Education Statistics. (1998). *Violence and Discipline Problems in U.S. Public Schools*. Washington, DC: Author.

Powell, K., Muir-McClain, L., & Halasyaman, L. (1995). A review of selected school-based conflict resolution and peer mediation projects. *Journal of School Health, 65*, 426-430.

Sabella, R. S., & Myrick, R. D. (1995). *Confronting sexual harassment: Learning activities for teens*. Minneapolis, MN: Educational Media.

Schmidt, F., Friedman, A., & Marvel, J. (1992). *Mediation for kids*. Miami, FL: Peace Education Foundation, Inc.

Schrumpf, F., Crawford, D. K., & Bodine, R. J. (1997). *Peer mediation*. Champaign, IL: Research Press.

Sciacca, J. (1995). Youth violence prevention through peer helping programs. *The Peer Facilitator Quarterly, 13*, 3-5.

Silver, E., Coupey, S., Bauman, L., Doctors, S., & Boeck, M. (1992). Effects of peer counseling training on psychological functioning of adolescents. *Journal of Adolescent Research, 7*, 110-127.

Snyder H. N., Sickmund M., Poe-Yamagata E. (1997). *Juvenile offenders and victims: 1997 update on violence*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Snyder, H. N., & Sickmund, M. (1999). *Juvenile offenders and victims: 1999 national report*. Washington, DC: U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Sorenson, D. (1992). *Conflict resolution and mediation for peer helpers*. Minneapolis, MN: Educational Media Corporation.

Thompson, S. (1996). Peer mediation: A peaceful solution. *The School Counselor, 44*, 151-154.

Tindall, J. (1995). *Peer programs: An indepth look at peer helping*. Bristol, PA: Accelerated Development.

Tobias, A., & Myrick, R. D. (1999). A peer facilitator-led intervention with middle school problem-behavior students. *Professional School Counselor, 3*, 27-33.

Tobler, N. (1986). Meta-analysis of 143 adolescent drug prevention programs: Quantitative outcome results of program participants compared to a control or comparison group. *Journal of Drug Issues, 16*, 20-27.

Trevaskis, D. (1994). *Mediation in the schools*. ERIC Digest (ED378108). Bloomington, IN: ERIC Clearinghouse for Social Studies/Social Science Education.

Vanayan, M. (1997). Would you like to be a peer mediator? Willingness to be a peer mediator among elementary students. *Alberta Journal of Educational Research, 43*, 57-60.

National Center for Education Statistics. (1998). *Violence and discipline problems in U.S. public schools*. Washington, DC: Author.

Wittmer, J., Thompson, D., & Sheperis, C. (1999). *The Peace Train*. Minneapolis, MN: Educational Media Corporation.

Zaragoza, N., Vaughn, S., & McIntosh, R. (1991). Social skills interventions and children with behavior problems: A review. *Behavioral Disorders, 16*, 260-275.

11

危機

Suicide Prevention in Schools

John Kalafat, Ph.D.
Rutgers University

Philip J. Lazarus, Ph.D.
Florida International University

Suicide consistently ranks as the second or third leading cause of death for adolescents. Between 1960 and 1990, the suicide rate for 15- to 19-year-olds more than tripled from 3.6 to 11.3 per 100,000. From 1991 to 1996, the average suicide rate for this age group was 10.56. The suicide rate for 10- to 14-year-olds has increased 120% from 1980 (0.8) to 1996 (1.7). This ominous increase in the rates for the younger age groups appears to be following the trends for substance abuse. Among youths aged 15-19, firearm-related suicides accounted for 81% of the increase in the overall rate since 1980. The incidence of suicide *attempts* is considerably higher, with around 10% of adolescent respondents reporting attempts in various surveys (Centers for Disease Control and Prevention, 1995).

These trends spawned a variety of youth suicide-prevention initiatives, the vast majority of which were school-based prevention and intervention programs (Leenaars & Wenckstern, 1991). Following a period of declining interest in these programs in the mid-1990s, a renewed interest in school-based prevention has been spurred by the Surgeon General's Call to Action to Prevent Suicide (U.S. Public Health Service, 1999) and the National Strategy for Suicide Prevention: Goals and Objectives for Action (U.S. Public Health Service, 2001). These reports included a recommendation for developing safe and effective programs in educational settings for youths that address, among other things, peer support for seeking help.

The School Context

Any effort to implement and sustain a suicide prevention initiative in schools must take into account the characteristics of schools that make them uniquely suited for prevention, as well as the constraints that limit what schools can do in this area. Thus, a central aim of this chapter is to describe what programmatic effort schools can reasonably be expected to carry out in regard to suicide prevention.

The Report of the Second World Conference on Injury Control (Injury Control in the 1990s, 1993) recommended the following steps to reduce violence and suicide: programs to improve recognition, referral, shelter, and long-term therapeutic interventions for people at high risk for violent injury; programs to address not only the behavior of individuals, but also the behavior of community institutions and the community environment; and better dissemination of educational materials to people who have influence or access to people at risk.

As the community institution that has primary responsibility for socialization of youths, the school has substantial influence and access to at-risk youths. School education codes and statutes include the mandate to not only educate, but also to protect students (Davis & Sandoval, 1991). Thus, schools offer a logical setting for preventive interventions.

However, the responsibility for socialization and protection now carries with it the burden of dealing with youths coming from environments characterized by what Dryfoos (1994) called the "new morbidities" such as family disintegration, substance abuse, interpersonal violence, and sexually transmitted diseases. Along with these developments have come waves of school "reform" and a plethora of individual, or categorical, programs aimed at these risk behaviors.

The increasing demands on schools dictate that suicide-prevention programs (a) have a clear conceptual and empirical base; (b) fit within school mandates and culture; (c) use proven implementation and instructional strategies; (d) include all appropriate components of the school and community (that is, they must be comprehensive and ecological or systemic); and (e) be efficient in the use of school resources.

The following sections review the research that informs school prevention programs and describe some school programs that draw on this research. The chapter concludes with an overview of comprehensive school suicide-prevention programs and the current empirical support for such programs.

Conceptual/Empirical Base

According to Caplan's (1964) classic paradigm, disorders can be prevented by reducing stressors or risk factors and/or enhancing supports or protective factors. Risk and protective factors are characteristics of individuals and/or their environments that increase or decrease, respectively, the probability of suicidal behavior. Research has begun to identify risk factors for suicide and to specify particularly potent combinations of these risk factors (Stoelb & Chiriboga, 1998; U. S. Public Health Service, 1999; U.S. Public Health Service, 2001). These risk factors are listed in Table 1.

It should be noted that even the presence of potent combinations of risk factors results in high rates of false positives, thus attenuating their efficiency for identifying suicidal individuals. In addition, aside from the first three, these risk factors are not specific to suicide. That is, they are associated with a broad array of other disorders,

Table 1

Risk Factors

- Previous suicide attempt
- Current ideation, intent, and plan (resolve)
- Exposure to suicide and/or family history of suicide
- Mental disorders—particularly mood disorders such as depression and bipolar disorder
- Personality disorders (conduct and borderline)
- Influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations
- Local epidemics of suicide that have a contagious influence
- Co-occurring mental and alcohol and substance abuse disorders
- Hopelessness and helplessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss
- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Isolation, a feeling of being cut off from other people
- Ineffective coping mechanisms and inadequate problem-solving skills
- A confluence of multiple stressors (discipline, rejection/humiliation, end of romantic relationship, conflict with family or peers, unmet school goals)

---

which are themselves often employed as predictors of youth suicide. Suicide is not a disease caused by specific agents, but is multiply determined and is comorbid with other disorders and destructive behaviors.

In addition, researchers have identified stressful events that often precede suicide in youth (Gould & Kramer, 2001; U.S. Public Health Service, 2001). Rather than causes of suicide, these precipitants appear to trigger suicidal behavior in vulnerable youths. These possible precipitants are listed in Table 2, on page 214.

All school personnel should be familiar with risk factors and precipitants. Some schools may be able to address some of these factors through comprehensive, on-site mental health services (Adelman & Taylor, 1997). Selected school personnel, particularly school screening and crisis response teams, can be trained to identify more effectively depressed and/or anxious youths. In general, however, typical school systems can address few factors on this list without considerable and sustained additional resources.

Table 2

Possible Suicide Precipitants

- Getting into trouble with authorities (e.g., school, police); not knowing and afraid of the consequences.
- Breakup from boyfriend or girlfriend.
- Death of a loved one or significant person.
- Disappointment and rejection such as a dispute with boy/girlfriend, failure to get a job, or rejection from college.
- Bullying or victimization.
- Conflict with family or family dysfunction.
- Disappointment with school results or school failure.
- High demands at school during examination periods.
- Unwanted pregnancy, abortion.
- Infection with HIV or other sexually transmitted diseases.
- The anniversary of a death of a friend or loved one.
- Knowing someone who committed suicide.
- Separation from friends, girlfriends/boyfriends.
- Real or perceived loss.
- Serious physical illness.
- Serious injury that may change the individual's life course.

Screening programs have been promoted to schools (Shaffer, 1999), but these are costly and require active parental consent. Moreover, because students' reported suicidal feelings are not stable or consistent, multiple screenings per year would be required. Thus, such programs fall outside of regular school mandates and are an inefficient use of resources.

On the other hand, the promotion of protective factors appears to be within the purview of schools. Protective factors that have been associated with preventing destructive behaviors are:

- Personal characteristics such as positive disposition and problem-solving ability.
- Contact with a caring adult.
- A sense of connection with school or community that is based on opportunities to participate and make contributions.

These characteristics can attenuate the likelihood of destructive behaviors, even by those who experience one or more risk factors. Some prospective studies have found these protective factors to be more powerful predictors of outcomes than risk factors (Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995). Furthermore, these appear to be general protective factors that moderate a variety of risk factors, including substance abuse, delinquency, violent behavior, and suicide (Elias, Gara, Schuyler, Branden-Muller, & Sayette, 1991; Evans, Smith, Hill, Albers, & Nuefeld, 1996; Jessor, et al., 1995; McBride et al., 1995). Therefore, efforts to promote protective factors would be an efficient prevention strategy for schools. Clearly, the promotion of problem solving and an environment that supports participation and contact with caring adults and fostering a sense of belonging to the school is within the education, socialization, and protection mandates of schools.

Modifying school environments and implementing multigrade social skills and problem-solving programs take time, and these efforts will not prevent the occurrence of all suicidal feelings, plans, or attempts (Weissberg & Elias, 1993). Therefore, another role for schools in the prevention of suicide involves identifying and responding to at-risk students. A focused, efficient, categorical program is needed to establish this capacity. The role of schools in this endeavor is critical, but is limited to the identification and subsequent referral to a specialized school or to community-based mental health services.

School-Based Suicide-Response Programs

School-based suicide-prevention programs can fall into any one of three categories developed by the Institute of Medicine (1994):

1. *Universal* interventions, which are directed at an entire population rather than selected subpopulations or individuals. The generic programs that promote protective factors are examples of this type of intervention, as are the comprehensive programs described in the next section.

2. *Selective* interventions, which are targeted to subpopulations that are characterized by shared exposure to some epidemiologically determined risk factor(s). For example, students at critical transitional periods, such as entering middle school or high school, can be at greater risk for a variety of adjustment and/or academic problems.

3. *Indicated* interventions, which are targeted to specific individuals who are already at preclinical levels of a disorder and who have been identified through screening procedures. For example, students who self-identify or who are identified by others as having suicidal thoughts or plans are referred for an appropriate treatment.

It is important to note that these are complementary, not competing, approaches [National Institute of Mental Health (NIMH), 1995]. Schools are encouraged to use universal, selective, and indicated prevention strategies as part of a comprehensive strategy.

Eggert and her colleagues have reported controlled studies that evaluated the implementation fidelity and proximal outcomes of a conceptually grounded, indicated prevention program (Eggert, Thompson, Herting, & Nicholas, 1995; Thompson, Eggert, Randell, & Pike, 2001). Participants were identified through a screening procedure that first identified potential dropouts and then screened these students for suicide risk. The 12 sessions emphasized coping and problem solving as well as establishing a connection with the school. Interestingly, both the 12-session intervention and the comparison condition, which consisted of a 2-hour assessment interview, a brief counseling interview, connection with a specific school-based adult, and a parent contact, were associated with reductions in suicide risk behaviors, depression, anger control problems, and family distress. This result is encouraging in that with training, schools may be able to intervene effectively with identified suicidal students with a relatively brief, focused intervention.

Universal suicide-prevention programs are designed to prepare the entire school community to respond to youths at risk for suicide, and they can incorporate the characteristics of effective and efficient programs noted in this chapter. The overall goals of the universal program are to increase the likelihood that school gatekeepers (administrators, faculty, staff, and peers) who come into contact with at-risk youths can more readily identify them, provide an appropriate initial response, know how to obtain help for them, and are *consistently inclined* to take such action.

These goals are based on the following findings:

- Most suicidal youths confide their concerns to peers rather than to adults (Dubow, Kausch, Blum, Reed, & Bush, 1989; Kalafat & Elias, 1992).
- Disturbed youths (e.g., depressed, substance abusers) prefer peer support over adult support more than do their nondisturbed peers (Naginy & Swisher, 1990; Offer, Howard, Schonert, & Ostrov, 1991).
- Some adolescents, particularly males, do not respond to troubled peers in empathic or helpful ways (Norton, Durlak, & Richards, 1989; Wellman & Wellman, 1986).
- As few as 25% of peer confidants tell an adult about their troubled or suicidal peer (Kalafat & Elias, 1992; Kalafat, Elias, & Gara, 1993).
- School personnel are consistently among the *last* choices of adolescents for discussing personal concerns. Therefore, the reluctance of adolescents to seek out helpful adults is considered to be a *risk factor* that contributes to destructive outcomes associated with a variety of adolescent risk behaviors (Lindsey & Kalafat, 1998).
- There is also evidence that *provision* of help by youths may be beneficial: participation in helping interactions can shape prosocial behaviors and reduce problematic behavior and is related to indices of social competencies that can carry over to other challenging situations (Allen, Aber, & Leadbeater, 1990).

227

To meet these goals, comprehensive universal suicide-prevention programs include the following components, usually implemented in this order:

1. *Administrative consultation* to ensure that policies and procedures for responding to at-risk students, attempts, and completions are in place and to ensure that community linkages exist for close coordination of referrals to, and return of students from, community gatekeepers. This one-time consultation usually takes a number of hours depending on the current status of the particular school.

2. *School gatekeeper training* for all faculty and staff (including such staff as bus drivers and cafeteria workers) on the identification of, initial response to, and effective referral of troubled and at-risk students. This training includes the role of the school, risk factors and warning signs, myths about suicide, guidelines for initial response and referral, a review of school policies, and school and community resources. This step sometimes includes the establishment of in school crisis response teams made up of faculty, staff, and administrators. The gatekeeper training can be accomplished in two hours and can be repeated every two years or so.

3. *Parent training* covering material similar to the school gatekeeper training, as well as means restriction strategies. This is usually a 1.5-hour presentation that is often coupled with other presentations or activities. Often parents do not see the relevance of suicide prevention to their own children; therefore, other activities are planned.

4. *Community gatekeeper training* that incorporates policies and procedures for effective response and coordination with schools and families. This step sometimes includes training in the treatment of depressed and suicidal adolescents, because this competency cannot be assumed. This component is not the responsibility of the school, but must be in place if the school is to have a reliable referral source. Community crisis teams and media campaigns have also been implemented as part of the community effort.

5. *Student classes*, which usually consist of four to five class periods included in the health curriculum. The classes can be used with any grade from 8 through 12, but are usually given in 8th or 9th grade, with short boosters in later grades.

Again, general programs on problem solving, self-esteem, and the like can form a foundation in elementary grades for this categorical suicide-response program. Classes include a variety of media that involve students in discussions and role-playing to prepare them to recognize and respond to troubled peers and to destigmatize seeking adult help. These classes do *not* aim to address suicidal feelings or behaviors; rather, they emphasize *help-seeking* skills and resources, and are primarily aimed at students who often come in contact with at-risk peers, and are secondarily aimed at the at-risk students themselves. The focus on help-seeking is relevant to other risk behaviors such as interpersonal violence, because recent events have shown that peers and adults often knew of warning signs but failed to take action (Vossekuil, Reddy, Fein, Borum & Modzeleski, 2000). Because the classes address more than one risk behavior, they are an efficient use of school resources.

These components address the comprehensive and ecological criteria, although more work must be done in most schools to increase the psychological, temporal, and cultural accessibility of adults if students are to follow through with the lessons learned in the health classes (Lindsey & Kalafat, 1998).

Such a universal prevention program fits within the school's resources and culture because it is a turnkey program that has an educational focus. The classroom curriculum consists of packaged, self-contained lesson plans for teachers to provide, and fits within the existing curriculum structure without requiring pull-out activities. The curriculum also uses appropriate instructional principles such as participatory activities, skills practice and feedback, and reinforcement and acknowledgment of students' experience (in dealing with troubled peers).[1]

Evaluation of School-Based Programs

Evaluations of programs implemented in the early 1980s to respond to concerns about youth suicide were mixed, suggesting that programs lacked sufficient focus and had not reached a point where their status could be evaluated (Overholser, Hemstreet, Spirito, & Vyse, 1989; Shaffer, Garland, Vieland, Underwood, & Busner, 1991; Spirito, Overholser, Ashworth, Morgan, & Benedict-Drew, 1988; Wholey, 1979). In program evaluation parlance, these are referred to as first-generation programs because it is recognized that program development and evaluation occur in an iterative cycle.

Drawing on the experiences of the initial programmatic efforts, many second-generation programs were more focused on preparing students to respond to encounters with at-risk peers and to seek adult help. Controlled evaluations of these programs have been more promising, suggesting that carefully implemented classroom curricula may enhance the inclination of students to obtain adult help for troubled peers (Ciffone, 1993; Kalafat & Elias, 1994; Kalafat & Gagliano, 1996).

Drawing on the findings of impaired problem solving among suicidal youths, Orbach and Bar-Joseph (1993) evaluated a universal prevention program that included a wide range of topics: depression and happiness, family issues, feelings of helplessness, coping with failure, coping with stress and problem solving, and coping with suicidal urges. Significant positive changes were found for the class participants compared with controls in reduction of suicidal feelings, increased ego identity cohesion, and ability to cope with problems.

In regard to school gatekeeper training, one study (Shaffer, Garland, & Whittle, 1988) found that one two-hour presentation to educators resulted in significant increases in knowledge of suicide warning signs and community resources. Reisman & Scharfman (1991) reported positive effects on guidance counselors' knowledge, attitudes, and referral practices after a six-session training program.

It must be noted that changes in knowledge and attitudes do not necessarily translate into changes in behavior. Research needs to be done that provides evidence for the relationship between these proximal outcomes and intermediate behavioral outcomes such as increased identification and referral of at-risk youths by school-based adults and students. A systemic approach to suicide prevention also requires the effective treatment and follow-up of identified youths (Kalafat, 2001). Moreover, in order to assess distal program effects (reduction of suicide rates) programs must be:

- Carefully implemented with fidelity.
- Designed to address multiple levels of school and community contexts (i.e., administrative policies and procedures; education for all school staff; classroom curricula; parent education; connections between school and community gatekeepers).
- Disseminated to enough sites to obtain large population samples for epidemiological impact assessment.
- Institutionalized over sufficient length of time in order to detect epidemiological trends.

Data are available from two programs that meet these criteria. The programs were developed and implemented by a county (New Jersey) community mental health center (Kalafat & Ryerson, 1999) and a county (Florida) public school Department of Crisis Management (Zenere & Lazarus, 1997). Each program was systematically disseminated and sustained over a period of 10 years in schools in both urban and suburban counties. Each program aimed to prepare schools and communities to identify, respond to, and obtain help for at risk youths, as well as covered other health topics such as substance abuse, coping, and self-efficacy.

The Miami-Dade County Public School (M-DCPS) program included additional health promotion programming for elementary and middle schools. The elementary school curriculum focuses on self-awareness development, communication skills, decision-making skills, drug information, and development of positive alternatives. The middle school curriculum stresses assertiveness, stress management, decision making, and conflict resolution. The topic of suicide is formally introduced in the 10th grade in a mandatory, one-semester curriculum entitled Life Management Skills.

These two programs were comprehensive in that they promoted linkages among school and community services and included school-based crisis teams, community crisis response capability, administrative polices and procedures, training for school personnel, parents, students, and, to a lesser extent, community gatekeepers. Follow-up studies showed a reduction in county youth suicide rates associated with the dissemination of the programs that was not replicated for the states or nationally for the same time periods (Kalafat, 2000). It was particularly noteworthy that no student who was identified by the Florida program as experiencing a suicidal ideation or suicidal attempt and therefore received intervention from M-DCPS later committed suicide. On the negative side, a review of the M-DCPS students who completed suicide between the 1989-1990 and 1993-1994 period revealed no reported previous ideations or attempts that came to the attention of school authorities among these victims. Basically, this means that it is imperative to identify suicidal students because, once identified, it is likely that their suicide can be prevented. It was only those students who never came to the attention of crisis team members that later took their own lives.

While these data cannot be conclusively linked to the programs, taken together, they meet some of the epidemiological criteria for supporting the possibility of causal relationships. These criteria include consistency of findings across studies, temporal sequence of exposure and outcome, and logical plausibility of the relationship (Potter, Powell, & Kachur, 1995) and provide encouraging initial support for comprehensive, community-oriented prevention approaches. These data also provide additional strong evidence against the myth that talking about suicide with youths will promote suicidal behavior.

Summary and Recommendations

School-based suicide-prevention programs emphasize competencies involved in obtaining help, including knowing the warning signs, dispelling suicide myths, connecting to resources, and resolving to take action. In addition, classroom lessons for students should not be implemented until all adults in the school have received education about suicide and have been informed about policies and procedures for identifying and responding to at-risk students and until schools and community services have coordinated referral and treatment procedures.

School-based suicide-prevention programs should be well-grounded in theory and supported by empirical research. Comprehensive school programs need to link the school with appropriate resources. There is some evidence to support the assumption that school-based programs can reduce suicidal behavior and save lives. However, lives can be saved only through a well-coordinated system that identifies students who have experienced suicidal behavior and gets them immediate help. All school staff and students need to be trained to refer suicidal youths for appropriate help.

School psychologists and other school mental health professionals can fill several important roles in regard to school suicide-prevention programs. Their training places them in a unique position to provide current, accurate information on empirically supported approaches, conduct training on risk assessment and crisis intervention, provide indicated programs, and facilitate collaboration between community service providers and schools.

References

Allen, J. P., Aber, J. L., & Leadbeater, B. J. (1990). Adolescent problem behaviors: The influence of attachment and autonomy. *Psychiatric Clinics of North America, 13*, 455-467

Adelman, H. S., & Taylor, L. (1997). System reform to address barriers to learning: Beyond school-linked services and full service schools. *American Journal of Orthopsychiatry*, 67, 408-421.

Caplan, G. (1964). *Principles of preventative psychiatry*. New York: Basic Books.

Centers for Disease Control and Prevention. (1995). Suicide among children, adolescents, and young adults. *Morbidity and Mortality Weekly Report* 44 *(15)*, 289-291.

Ciffone, J. (1993). Suicide prevention: A classroom presentation to adolescents. *Social Work*, 38, 196-203.

Davis, J. M., & Sandoval, J. (1991). *Suicidal youth: School-based intervention and prevention*. San Francisco: Jossey-Bass.

Dryfoos, J. G. (1994). *Full service schools*. San Francisco: Jossey-Bass.

Dubow, E. F., Kausch, D. F., Blum, M. C., Reed, J., & Bush, E. (1989). Correlates of suicidal ideation and attempts in a community sample of junior high and high school students. *Journal of Clinical Child Psychology*, *18*, 158-166.

Eggert, L. L., Thompson, E. A., Herting, J. R., & Nicholas, L. J. (1995). Reducing suicide potential among high-risk youth: Tests of a school-based prevention program. *Suicide & Life-Threatening Behavior*, *25*, 276-296.

Elias, M. J., Gara, M. A., Schuyler, T. F., Branden-Muller, L. R., & Sayette, M. A. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry*, *61*, 409-417.

Evans, W., Smith, M., Hill, G., Albers, E., & Nuefeld, J. (1996). Rural adolescent views of risk and protective factors associated with suicide. *Crisis Intervention*, 3, 1-12.

Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide & Life-Threatening Behavior*, *31*, 6-31.

Injury control in the 1990s: A national plan for action. (1993). Atlanta, GA: Centers for Disease Control and Prevention.

Institute of Medicine. (1994). *Reducing risk for mental disorder: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

Jessor, R., Van Den Bos, J., Vanderryn, J., Costa, F. M., & Turbin, M. S. (1995). Protective factors in adolescent problem behavior: Moderator effects and developmental change. *Developmental Psychology*, *31*, 923-933.

Kalafat, J. (2000). Issues in the evaluation of youth suicide prevention initiatives. In T. Joiner & M. D. Rudd (Eds.), *Suicide science: Expanding the boundaries* (pp. 241-249). Boston: Kluwer Academic Publishers.

Kalafat, J. (2001, May). *A systems approach to youth suicide prevention*. Invited presentation at Institute of Medicine, The National Academies Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide Workshop on Suicide Prevention. Washington, DC.

Kalafat, J., & Elias, M. (1992). Adolescents' experience with and response to suicidal peers. *Suicide & Life-Threatening Behavior*, *22*, 315-321.

Kalafat, J., & Elias, M. (1994). An evaluation of adolescent suicide intervention classes. *Suicide & Life- Threatening Behavior, 24*, 224-233.

Kalafat, J., Elias, M., & Gara, M. A. (1993). The relationship of bystander intervention variables to adolescents' responses to suicidal peers. *Journal of Primary Prevention, 13*, 231-244.

Kalafat, J., & Gagliano, C. (1996). The use of simulations to assess the impact of an adolescent suicide response curriculum. *Suicide & Life-Threatening Behavior, 26*, 359-364.

Kalafat, J., & Ryerson, D. M. (1999). The implementation and institutionalization of a school-based youth suicide prevention program. *Journal of Primary Prevention, 19*, 157-175.

Leenaars, A. A., & Wenckstern, S. (1991). *Suicide prevention in schools*. NY: Hemisphere Publishing.

Lindsey, C. R., & Kalafat, J. (1998). Adolescents' views of preferred helper characteristics and barriers to seeking help. *Journal of Educational and Psychological Consultation*, 9, 171-193.

McBride, C. M., Curry, S. J., Cheadle, A., Anderman, C., Wagner, E. H., Diehr, P., & Psaty, B. (1995). School-level application of a social bonding model to adolescent risk-taking behavior. *Journal of School Health*, 65, 63-68.

Naginy, J. L., & Swisher, J. D. (1990). To whom would adolescents turn with drug problems? Implications for school professionals. *High School Journal, 73*, 80-85.

National Institute of Mental Health Committee on Prevention Research. (1995). *A plan for prevention research for the National Institute of Mental Health* (A report to the National Advisory Mental Health Council). Washington, DC: Author.

Norton, E. M., Durlak, J. A., & Richards, M. H. (1989). Peer knowledge of and reactions to adolescent suicide. *Journal of Youth and Adolescence, 18*, 427-437.

Offer, D., Howard, K. J., Schonert, K. A., & Ostrov, E. (1991). To whom do adolescents turn for help? Differences between disturbed and nondisturbed adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30, 623-630.

Orbach, I., & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity, and coping. *Suicide & Life-Threatening Behavior*, 23, 120-129.

Overholser, J. C., Hemstreet, A. H., Spirito, A., & Vyse, S. (1989). Suicide awareness programs in the schools: Effects of gender and personal experience. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*, 925-930.

Potter, L., Powell, K. E., & Kachur, P. S. (1995). Suicide prevention from a public health perspective. *Suicide & Life-Threatening Behavior, 25*, 82-91.

Reisman, B. A., & Scharfman, M. A. (1991). *Teenage suicide prevention workshops for guidance counselors* (trainer's manual & resource materials). Douglastown, NY: Pride of Judea Medical Center.

Shaffer, D. (1999, September). *School-based suicide prevention: Dos and don'ts: An overview of the Columbia teen screen project*. Zarrow Mental Health Symposium, Planning to Prevent Youth Violence and Self-Destructive Behavior, Tulsa, Oklahoma.

Shaffer, D., Garland, A., & Whittle, B. (1988). *An evaluation of youth suicide prevention programs.* New Jersey adolescent suicide prevention project: Final project report. Trenton, NJ: New Jersey Division of Mental Health and Hospitals.

Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30, 588-596.

Spirito, A., Overholser, J., Ashworth, S., Morgan, J., & Benedict-Drew, C. (1988). Evaluation of a suicide awareness curriculum for high school students. *Journal of the American Academy of Child & Adolescent Psychiatry*, 6, 705-711.

Stoelb, M., & Chiriboga, J. (1998). A process model for assessing adolescent risk for suicide. *Journal of Adolescence, 21*, 359-370.

Thompson, E. A., Eggert, L. L., Randell, B. P., & Pike, K. C. (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health*, 91, 742-752.

U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide.* Washington, DC: Author. Available Online: www.surgeongeneral.gov/library/calltoaction/fact1.htm

U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action.* A collaborative effort of SAMSHA, CDC, NIH, HRSA. Washington, DC. Author. Available Online: www.mentalhealth.org/publications/allpubs/SMA01-3518/index.htm

Vossekuil, B., Reddy, M., Fein, R., Borum, R., & Modzeleski, W. (2000). *U.S. S. S. Safe School Initiative: An interim report on the prevention of targeted violence in schools.* Washington, DC: U. S. Secret Service, National Threat Assessment Center.

Weissberg, R. P., & Elias, M. J. (1993). Enhancing young peoples' social competence and health behavior: An important challenge for educators, scientists, policymakers, and funders. *Applied & Preventive Psychology*, 2, 179-190.

Wellman, M. M., & Wellman, R. J. (1986). Sex differences in peer responsiveness to suicide ideation. *Suicide & Life-Threatening Behavior*, 16, 360-378.

Wholey J. (1979). *Evaluation: Promise and performance.* Washington, DC: The Urban Institute.

Zenere, F. J., III, & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide & Life-Threatening Behavior*, 27, 387-403.

Endnote

[1] Guidelines for the Implementation of School Programs, including a sample curriculum outline, are available from the American Association of Suicidology.

12

危機

Aggression Replacement Training

Arnold P. Goldstein, Ph.D.
Syracuse University

Barry Glick, Ph.D.
G & C Consultants, L.L.C. (Albany, NY)

This chapter describes the procedures and curriculum that constitute Aggression Replacement Training (ART); their diverse applications in school, agency, and residential settings; and an extended series of evaluations of their efficacy to change behavior. Throughout these examinations, particular emphasis is placed on describing program management and implementation challenges and solutions.

ART Procedures and Curriculum

Teachers, counselors, juvenile corrections staff, and others who deal with aggressive youths understand that these youngsters often engage in high levels of acting-out behaviors combined with deficient alternative prosocial behaviors. Many aggressive youths are skilled in fighting, bullying, intimidating, harassing, and manipulating others. They frequently lack socially desirable behaviors, such as negotiating agreements, identifying their own and others' feelings, dealing appropriately with accusations, and responding effectively to failure, teasing, rejection, or anger. ART is our response to these antisocial behavior excesses and prosocial behavior deficits. It is a multimodal, psychoeducational intervention that consists of (a) Skillstreaming, (b) Anger-Control Training, and (c) Moral Reasoning Training. These three components, when integrated and coordinated as we have designed, constitute a cognitive-behavioral intervention program targeted to the participating youths' thinking, affect, and overt behavior.

Skillstreaming

A 50-skill intervention curriculum of prosocial behaviors, Skillstreaming is systematically taught to chronically aggressive adolescents (Goldstein, Sprafkin, Gershaw, & Klein, 1980) and younger children (McGinnis & Goldstein, 1984, 1990). The

Skillstreaming curriculum is implemented with small groups of such trainees (preferably six to eight). The following teaching procedures are employed:

- ***Modeling***—The groups see several examples of experts using the behaviors and the skills in which they are weak or lacking.
- ***Role-playing***—Individuals are given several guided opportunities to practice and rehearse competent interpersonal behaviors.
- ***Performance feedback***—Instructors praise and provide feedback on how well the juvenile's role-play of the skill matched the expert model's portrayal of it. Reinstruction is given when necessary.
- ***Generalization training***—Trainees are encouraged to practice what they have seen modeled and tried in their role-play via a series of activities, such as regularly completing skill homework assignments, that are designed to increase the chances that they will be able to use the skills in their real-life environment—school, institution, home, community, or other settings.

Table 1 lists the prosocial skills that participating youngsters learn from these procedures.

Table 1

Skillstreaming Skills for Adolescents

Group I.	Beginning Social Skills	
	Skill 1.	Listening
	Skill 2.	Starting a conversation
	Skill 3.	Having a conversation
	Skill 4.	Asking a question
	Skill 5.	Saying thank you
	Skill 6.	Introducing yourself
	Skill 7.	Introducing other people
	Skill 8.	Giving a compliment
Group II.	**Advanced Social Skills**	
	Skill 9.	Asking for help
	Skill 10.	Joining in
	Skill 11.	Giving instructions
	Skill 12.	Following instructions
	Skill 13.	Apologizing
	Skill 14.	Convincing others

BEST COPY AVAILABLE

Skill 15. Knowing your feelings
Skill 16. Expressing your feelings
Skill 17. Understanding the feelings of others
Skill 18. Dealing with someone else's anger
Skill 19. Expressing affection
Skill 20. Dealing with fear
Skill 21. Rewarding yourself

Skill 22. Asking permission
Skill 23. Sharing something
Skill 24. Helping others
Skill 25. Negotiating
Skill 26. Using self-control
Skill 27. Standing up for your rights
Skill 28. Responding to teasing
Skill 29. Avoiding trouble with others
Skill 30. Keeping out of fights

Skill 31. Making a complaint
Skill 32. Answering a complaint
Skill 33. Sportsmanship after the game
Skill 34. Dealing with embarrassment
Skill 35. Dealing with being left out
Skill 36. Standing up for a friend
Skill 37. Responding to persuasion
Skill 38. Responding to failure
Skill 39. Dealing with confusing messages
Skill 40. Dealing with an accusation
Skill 41. Getting ready for a difficult conversation
Skill 42. Dealing with group pressure

Skill 43. Deciding on something to do
Skill 44. Deciding what caused a problem
Skill 45. Setting a goal
Skill 46. Deciding on your abilities
Skill 47. Gathering information
Skill 48. Arranging problems by importance
Skill 49. Making a decision
Skill 50. Concentrating on a task

Anger Control Training

First developed by Feindler, Marriott, and Iwata (1984), Anger Control Training is partially based on the earlier anger control and stress inoculation research of Novaco (1975) and Meichenbaum (1977). Its goal is to teach adolescent or child trainees to control their own anger. In Anger Control Training, the participating youngsters must bring to each session one or more descriptions of recent anger-arousing experiences. Usually those experiences are written in their "Hassle Log." During 10 sessions, the trainees are trained to respond to their hassles with a chain of behaviors that include:

- ***Identifying triggers*** (external events and internal self-statements that provoke an anger response).

- ***Identifying clues*** (individual kinesthetic or physical experiences, such as tightened muscles, flushed faces, and clenched fists that let the individual know that the emotion he or she is experiencing is anger).

- ***Using reducers*** (techniques that are designed to lower the individual's level of anger, such as deep breathing, counting backward, imaging a peaceful scene, or imagining the long-term consequences of one's behavior).

- ***Using reminders*** (self-statements, such as "stay calm," "chill out," and "cool down," or nonhostile explanations of others' behaviors).

- ***Using self-evaluation*** (reflecting on how well they responded to the hassle by identifying triggers and cues, using reminders, and using reducers and then praising or rewarding oneself for effective performance).

The juvenile trainees, who participate in both Skillstreaming and Anger Control Training, become knowledgeable about what to do (from Skillstreaming) and what not to do (from Anger Control Training) in circumstances that instigate aggression. However, because aggressive behavior is so consistently, immediately, and richly rewarded in many of the real-world settings in which adolescents and younger children live, work, go to school, and interact, they may still consciously choose to behave aggressively. Thus, we believed that it was important to add a values-oriented component to this intervention approach.

Moral Reasoning Training

Moral Reasoning Training is a set of procedures designed to enhance the youngster's sense of fairness, justice, and concern with the needs and rights of others. In a pioneering series of investigations, Kohlberg (1969, 1973) demonstrated that exposing young persons to a series of moral dilemmas (through discussion groups that include trainees reasoning at differing levels of morality) arouses cognitive conflict. When resolved, this cognitive conflict will frequently advance a participant's moral reasoning to that of his or her peers in the group who reason at a higher level. Such advancement of moral reasoning is a reliable finding but, as with many other single-component interventions, efforts to use it alone as a means of enhancing actual, overt moral behavior have resulted in mixed success (Arbuthnot & Gordon 1983; Zimmerman 1983).

We thus reasoned that Kohlberg's Moral Reasoning Training [and in recent implementations of ART, the closely related approach, Social Problem Solving developed by Gibbs (1999)] has marked potential for providing constructive direction toward improved sociability. It can aid in moving youngsters away from antisocial behavior by adding to their behavioral repertories the actual skills for acting prosocially or for successfully inhibiting antisocial behaviors. Because a combination of all three components–Skillstreaming, Anger Control Training, and Moral Reasoning Training–is a priori stronger than any component alone, we used all three to constitute ART. We and others have offered the ART curriculum in a variety of lengths, but a 10-week sequence has emerged as a "core" curriculum in several of its research evaluations (see this chapter's Appendix).

Application Innovations

Since its inception in 1987, ART programs have been put in place in a number of schools, agencies, and residential settings. A number of programs have creatively implemented the ART curriculum. This section provides a review of these applied innovations.

An Alternative School: Positive Alternative Learning (PAL) Program (St. Louis, MO)

An especially noteworthy feature of the PAL Program is its major outreach to the interpersonal systems of its target youths. After a student learns a new behavior, a new perception, a new way of coping or responding in an ART series, he or she goes out to interact with key people who respond to these new ways of being. If these real-world figures respond with indifference or even hostility to the youngster's efforts, the new behaviors and perceptions rapidly disappear. If, on the other hand, they respond with interest, praise, or approval, the behavioral changes have a much better chance to endure. At PAL the real-world figures are the school's staff, PAL peers, and the youngster's parents. The program makes an energetic and sustained effort to reach out to such figures, makes clear in concrete terms precisely how they can contribute positively to the behavior-change process, and monitors whether such a contribution is in fact being made. With parents, for example, PAL holds weekly parent empowerment meetings. At the beginning of each youth's stay at PAL, his or her parents are required, as a condition of the youth's acceptance into the program, to attend these meetings for eight weeks. Each parent meeting contains major elements of ART programming. If a parent fails to attend, a PAL staff member goes to the home the next morning and conducts an on-site skill lesson. If the parent continues to miss meetings, the youth is suspended from the program. Since the program's inception, only a few students have been dropped for parental nonattendance.

A Community Agency (Brooklyn, NY)

The Brownsville Neighborhood Youth Action Center offers a strong and consistent expectation for success. Beginning with their first trainee contact, program staff verbally and behaviorally deliver the message that: "You can succeed, stay out of jail, get your equivalency diploma, find and keep a job, and get along better with your family." Staff commitment to trainee success has been shown in the research literature, as well as in this particular program, to motivate, encourage, and set a standard that many youths emulate. In brief, the message of this agency's ART program is "expect the best of your trainees; it helps them to achieve it."

A Neighborhood Center: Youth Alternatives (Malmo, Sweden)

This creative program has for some years made particularly effective use of ART with criminally involved youths. Two features of the effort are especially noteworthy. First, its ART trainers, for their typically 11- to 15-year-old trainees, are themselves "graduates" of ART programs. The late adolescent and early adult trainers, all of whom had serious involvement with the juvenile justice system in their own earlier adolescent years, appear to constitute an unusually credible, easy to relate to, and effective model for their ART group trainees. Another approach worth emulating is the trainer-training sequence employed by Youth Alternatives. Its strategy may be described as "graduated apprenticeship." Trainers-in-training first observe Youth Alternatives staff, all of whom are highly experienced in ART administration, conduct actual ART sessions with delinquent youths. The trainers-in-training then co-lead with such staff mock ART groups (whose members are other staff role-playing delinquent youths) and then groups of actual youths. Following these observational and co-leading experiences, trainers in training lead youth groups while being observed by staff. Finally, they lead groups on their own, receiving supervision when and as needed. Such incremental, graduated accumulation of experiences, exposure, and supervisory feedback has consistently appeared to yield competent and highly effective ART trainers.

A School District (Erie, PA)

This school district's most significant achievement is its ability to stimulate and sustain staff involvement in ART delivery at numerous program sites over a long period of time. How do they do it? In brief, trainers are motivated by active participation in program development and amendment and by a process of consensus building and ongoing opportunity for trainer feedback. While program strategy (ART and others) and organizing philosophy are set largely at the district supervisory level, commitment to participatory management is communicated to, and carried out by, trainer staff at the program's tactical level. Program staff contributes substantially and on a continuing basis to decisions about their own program's content, intensity, staffing, structure, and more. In our opinion, the sense of joint ownership is a major factor in developing and maintaining levels of districtwide staff motivation.

A Residential School District (Children's Village, NY)

Staff training for competency in ART group leadership at Children's Village is operationalized as an apprenticeship program in which novice trainers participate in a series of orienting workshops followed by practice group experiences ("trainees" are staff playing the roles of residents). These experiences are followed by the supervised running of actual ART groups and, finally, by the unsupervised running of groups.

The challenge of intervention work—whether ART or another effort—is generalization. Does the training extend beyond the training room to other settings, and does it endure over time? At Children's Village, a major effort is made to extend the outcomes of the ART meetings to both the campus residence settings and to the residents' families. Using both formal and informal means of communication, the school, cottage, staff, and family regularly communicate and collaborate in the skill-acquisition and skill-performance efforts. Such generalization is not easily accomplished, but the effort at Children's Village to do so is broad and energetic and stands as a model to be emulated.

Evaluations of Effectiveness

Annsville Youth Center

Our first evaluation of ART was conducted at a New York State Division for Youth facility in central New York State (Goldstein & Glick, 1987). Sixty youths at Annsville were included, most of whom were incarcerated at this limited-security institution for such crimes as burglary, unarmed robbery, criminal mischief, and various drug offenses. Twenty-four youngsters received the 10-week ART program described earlier (see this chapter's Appendix). As noted, this program required them to attend three sessions per week, one each of Skillstreaming, Anger Control Training, and Moral Reasoning Training. An additional 24 youths were assigned to a no-ART, brief instruction control group. This group controlled for the possibility that any apparent ART-derived gains in skill performance were due not to ART per se, but to the youngsters' enhanced motivation to display skills they already possessed but simply were not using. A third group, the no-treatment control group, consisted of 12 youths not participating in either ART or the brief instruction control group.

The overall goal of this evaluation was to examine the effectiveness of ART for the purpose of:

- ***Skill acquisition:*** Do the youngsters learn the 10 Skillstreaming skills in the ART curriculum?

- ***Minimal skill transfer:*** Can the youngsters perform the skills in response to new situations similar in format to those in which they were trained?

- ***Extended skill transfer:*** Can the youngsters perform the skills in response to new situations dissimilar in format and more "real-lifelike" than those in which they were trained?

- ***Anger control enhancement:*** Do the youngsters actually demonstrate fewer altercations or other acting-out behaviors as reflected in weekly behavior incident reports, which are completed for all participating youths by the center's staff?

- ***Impulse reduction:*** Are the youngsters rated as less impulsive and more reflective and self-controlled in their interpersonal behaviors?

Analyses of study data revealed that youths undergoing ART significantly acquired and transferred (minimal and extended) 4 of the 10 Skillstreaming skills—Making a Complaint, Getting Ready for a Difficult Conversation, Dealing with Someone Else's Anger, and Dealing with Group Pressure—in comparison with youths in both control groups. Similarly significant ART versus control group comparisons emerged on both the number and intensity of in-facility acting-out behaviors (as measured by the behavior incident reports) as well as on staff-rated impulsiveness.

Following completion of the project's post-testing, in Week 11 new ART groups were formed for the 36 youths in the two control groups. As before, these sessions were held 3 times per week for 10 weeks and duplicated the first-phase ART sessions in all other major respects (curriculum, group size, materials, etc.). Our goal in this second phase was an own control test of the efficacy of ART, with particular attention to discerning possible reductions in acting-out behaviors by comparing, for these youths, their behavior incident reports during Weeks 11 through 20 (when in ART) with their behavior incident reports from the period when they had served as control group members (Weeks 1 through 10). Both of the statistical comparisons (number and severity) conducted to test this replication effect yielded positive results.

Real-world figures such as family and peers frequently express indifference or even hostility toward trainees' use of newly learned prosocial skills. As a result, incarcerated delinquents experience considerable difficulty in effecting the transfer of skills from the more protective and benign training environment to the community environment. Family and peers frequently serve as reinforcers of antisocial behaviors, ignoring or even punishing constructive alternative actions. Our hope was that ART would serve as a sufficiently powerful intervention to effect at least moderate carryover of in-facility ART gangs.

To test for such possible transfer effects, we constructed a global rating measurement of community functioning. During the 1-year period following initiation of ART at Annsville, 54 youths were released from this facility. Seventeen had received ART;

37 had not. We contacted the Division for Youth team members (analogous to parole officers) around New York State to whom the 54 released youths regularly reported and, without informing the workers as to whether the youths had or had not received ART, asked the workers to complete global rating measurements for each of the Annsville youths. In four of the six areas—namely, home and family, peer, legal, and overall—ART youths were rated significantly higher with regard to in-community functioning than were youths who had not received ART. In the areas of school and work, no significant differences emerged.

MacCormick Youth Center

Our second evaluation of the efficacy of ART was conducted at MacCormick Youth Center, a New York State Division for Youth maximum-security facility for male juvenile delinquents between the ages of 13 and 21 (Goldstein & Glick, 1987). In essence, this second evaluation project sought to replicate the procedures and findings of the Annsville project and to include youths incarcerated for substantially more serious felonies. Fifty-one youths were in residence at MacCormick at the time of the evaluation. Crimes committed by these youths included murder, manslaughter, rape, sodomy, attempted murder, assault, and armed robbery. In all its procedural and experimental particulars, the MacCormick evaluation project replicated the effort at Annsville. It employed the same preparatory activities, materials, curriculum, testing, staff training, residential training, supervision, and data-analysis procedures.

On 5 of the 10 Skillstreaming skills, significant acquisition and/or transfer results emerged. These findings essentially replicate the Annsville Skillstreaming results. In contrast to the Annsville results, however, the MacCormick data also yielded a significant result on the Sociomoral Reflection Measure (Basinger, Gibbs, & Fuller, 1995). At MacCormick, but not at Annsville, youths participating in Moral Reasoning Training sessions grew significantly in moral reasoning stages over the 10-week intervention period.

Regarding overt, in-facility behavior, youths receiving ART, compared with those who did not, increased significantly over their base rate levels in their use of constructive, prosocial behaviors (e.g., offering or accepting criticism appropriately, employing self-control when provoked) and decreased significantly in their rated levels of impulsiveness. In contrast to the Annsville findings, MacCormick youths who received ART did not differ from controls in either the number or intensity of acting-out behaviors. Annsville, internally, is not a locked facility. Its 60 youths live in one dormitory, in contrast to the locked, single-room arrangement at MacCormick. MacCormick's staff is twice the size of Annsville's, and the facility operates under a considerably tighter system of sanctions and controls than does Annsville. Because of these operational differences, the opportunity for acting-out behaviors is lower across all conditions at MacCormick as compared with Annsville. A "floor effect" therefore seemed to be operating at MacCormick that made a decrease in acting-out at MacCormick less likely to be a direct result of ART participation than at Annsville. At Annsville, such behaviors were contextually more possible at base rate, and they could (and did) decrease over the intervention period. At MacCormick, all youths started with low base rates and, likely for these same contextual reasons (e.g., sanctions, controls, rich staffing, etc.), they remained low. Subjects' use of prosocial behaviors, to which no floor or ceiling influences were relevant, did increase differentially as a function of the ART intervention.

A Community-Based Evaluation

The findings of our first two investigations revealed ART to be a multimodal, habilitation intervention of considerable potency with incarcerated juvenile delinquents. It enhanced prosocial skill competency and overt prosocial behavior and reduced levels of impulsiveness. In addition, in one of the two samples studied, we verified decreases (where possible) in the frequency and intensity of acting-out behaviors and enhancement of participants' levels of moral reasoning.

Furthermore, some evidence provided independently revealed ART to lead to valuable changes in community functioning. In light of the general movement away from residential-based and toward community-based programming for delinquent youths, this possibility for community change led to our third evaluation of the efficacy of ART. "This evaluation sought to discern the value of ART when provided to youths (33 in the two experimental conditions and 32 in the no ART control condition) on a post-release basis, while youths were living in the community." (Goldstein, Glick, Irwin, Pask-McCartney, & Rubama, 1989). We were aware of the potent contribution to effective community functioning that parents and others make in the lives of delinquent youths. This belief led to our attempt to discern the effects of offering ART not only to the youths, but also to their parents and other family members.

This community-based project was essentially a three-way comparison of ART provided directly to youths plus ART provided to youths' parents or other family members (Condition 1), versus ART for youths only (Condition 2), versus a no-ART control group (Condition 3). For the most part, participating youths were assigned to project conditions on a random basis, with departures from randomization becoming necessary on occasion as a function of the five-city, multisite, time-extended nature of the project. Largely as a result of how long the New York State Division for Youth had aftercare responsibility for youths discharged from their facilities, the ART program offered to project participants was designed to last 3 months, with sessions meeting twice per week, for a total of approximately 24 sessions. Each session, 1.5 to 2 hours long, was spent in (a) brief discussion of current life events and difficulties; (b) Skillstreaming training of a skill relevant to the life events/difficulties discussed; and, on an alternating basis, (c) Anger Control Training or Moral Reasoning Training. Once weekly, an ART session was held for the parents and other family members of a sample of participating youths. Those parents selected to participate, but who did not appear, were provided ART in modified form via a weekly home visit or telephone call.

Since the different ART groups comprising the project's two treatment conditions chose which of the 50 Skillstreaming skills they wished to learn, different groups learned different (if overlapping) skills. We did not, therefore, examine in our statistical analyses participant change on individual skills. Instead, analyses focused on total skill change for the youths participating in ART (Conditions 1 and 2) versus each other and non-ART control group youths (Condition 3). Results indicated that, although results for the two ART conditions did not differ significantly, participants in each of these conditions increased significantly in their overall interpersonal skill competence when compared with Condition 3 (no-ART) youths. A similarly significant outcome emerged (both ART groups versus no-ART group) for decrease in self-reported anger levels in response to mild (e.g., minor nuisance, unfair treatment), but not severe (e.g., betrayal of trust, control/coercion, physical abuse) anger-provoking situations.

A particularly important evaluation criterion in delinquency intervention work is recidivism. The majority of previously incarcerated youths who recidivate do so within the first six months following their release (Maltz, 1984). Thus, the recidivism criterion employed in this project, re-arrest, was tracked during the first three months, in which youths received ART, and during the three subsequent no-ART months. Condition 3 youths, of course, received no ART during the entire tracking period. Analyses examining the frequency of re-arrest by condition showed a significant effect for ART participation. Both Condition 1 and Condition 2 youths were re-arrested significantly less than were youths not receiving ART. A substantial decrease in re-arrest occurred when the youths' families (i.e., parents and siblings) participated simultaneously in their own ART groups. Table 3 represents the actual frequency and percentages of re-arrests by condition.

Table 3

Frequency of Re-Arrest by Condition in the Community-Based Evaluation

Condition	Total N	Re-Arrested N	Percent Re-Arrested
Youth ART plus parent/sibling ART	13	2	15
Youth ART only	20	6	30
No-ART control	32	14	43

This study indicates that teaching family members interpersonal skills and anger-control techniques reciprocal to those the delinquent youths are learning may well provide the youths with a more responsive and prosocially reinforcing real-world environment—an environment in which prosocial, instead of antisocial, behaviors are supported, encouraged, and reinforced.

BEST COPY AVAILABLE

The Gang Intervention Project

Our research group's fourth ART evaluation (Goldstein, Glick, Carthan, & Blancero, 1994), in which trainees were all gang members, also grew from a systems-oriented spirit. If our community-based effort captured that part of the delinquent youths' interpersonal world made up of family members and turned it, at least in part, toward a prosocially reinforcing direction, could the same be done with delinquent gang youths and their peer groups (i.e., other gang members)? Could we use ART not only to teach youths to behave more prosocially, but also to increase the likelihood that their prosocial efforts in real life would be met by acceptance, support, and even praise from fellow gang members?

This project was conducted in two Brooklyn, New York, community-based agencies: the Brownsville Community Neighborhood Action Center and Youth D.A.R.E.S. of Coney Island. Each agency conducted three 4-month sequences of ART. Within each sequence, trainees were all members of the same gang. We created a control group for each sequence whose members were also from the same gang, but from a gang different than the one to which the ART trainees belonged. Thus, across both agencies, 12 different gangs participated in the program—6 receiving ART, 6 as no-ART controls. All the youths, ART and controls, received the same educational, vocational, and recreational services offered by the two participating agencies.

Repeated measures ANOVA crossing project conditions (ART versus control) with time of measurement (pre- versus post-study) revealed a significant interaction effect favoring ART participants for each of the seven Skillstreaming categories—Beginning Social Skills, Advanced Social Skills, Skills for Dealing with Feelings, Skill Alternatives to Aggressions, Skills for Dealing with Stress, and Planning Skills—as well as on a total skills score.

None of the ANOVA comparisons of ART scores with control group scores for the study's measure of anger control yielded significant differences. Of the five community domains, only work adjustment yielded a significant difference. This result accords well with (and no doubt largely reflects) the real-world employment pattern for project participants. For example, in the months immediately following their ART sequence, the majority of the participating "Lo-Lives" left their gang and took jobs in retail businesses. At an analogous point in time, following their own ART participation, a substantial minority of the participating "Baby Wolfpack" members obtained employment in the construction trades.

Arrest data were available for the youths participating in our first two ART gang-intervention sequences and their respective control groups. Five of the 38 ART participants (13%) and 14 of the 27 control group members (52%) were re-arrested during the 8-month tracking period (Chi square=6.08, p< .01). Our primary rationale for working with intact gangs in this project was the opportunity afforded by such a strategy to capture a major portion of the youth's environment and turn it in a prosocial direction. The question was, once trainees learned specific prosocial behaviors, would the transfer and maintenance of these skills be facilitated or discouraged by the people with whom the youths regularly interacted in the real-world environment? Our favorable outcome, verified by re-arrest rates, implies the possibility that a more harmonious and prosocially promotive post-ART peer environment was created. Although it is important for future research to examine the possibility more directly, it is of considerable interest to note that similar re-arrest outcomes were obtained in our earlier attempt to create a prosocially reinforcing post-ART environment for delinquent youths by employing this intervention with them and their families. For these youths (ART for self and family), re-arrest rates on follow-up were 15%; for no-ART control group youths, the comparable figure was 43%. Both of these outcomes from the community-based project closely parallel the outcomes found here (13% and 52%, respectively) for the presence or absence of support from a rather different type of "family"—fellow gang members.

The efficacy evaluations we have described above suggest that ART is an effective intervention. It appears to promote the acquisition and performance of skills, improve anger control, decrease the frequency of acting-out behaviors, and increase the frequency of prosocial behaviors. Beyond facility walls, its effects persist—less fully perhaps than when the juvenile is in a controlled environment, but the effects persist nonetheless. In general, the potency of the results appears to be adequate enough that its continued implementation and evaluation with chronically aggressive juveniles is clearly warranted. This encouraging conclusion is supported by additional investigations evaluating the efficacy of ART with trainees in agency, school, or institutional settings that were conducted by other investigators in widely dispersed research sites: Florida (Nodarse, 1998), Texas (Coleman, Pfeiffer, & Oakland, 1991), Tennessee (Nugent, Bruley, & Allen, 1999), Pennsylvania (M. Amendola, personal communication, November 17, 1997), Michigan (W. S. White, personal communication, August 5,1997), California (Kellner & Bry, 1999), Washington (Currulla, 1990), Ohio (Leeman, Gibbs, & Fuller, 1991), Brisbane, Australia (Jones, 1990), and Lima, Peru (Masias & Anicama, 1995).

Program Management

Management of a four-study, multisite intervention evaluation program lasting seven years and involving dozens of facility and agency staff as well as hundreds of juvenile trainees required diverse planning, training, supervision, data collection, data analysis, budget management, and resource coordination efforts. What have these efforts taught us?

Program Planning

Our experiences with these programs provide valuable information for both those who seek to replicate this project as well as those who are managing other programs.

Starting from the beginning of project planning, project managers must seek to plan not only good science (design, measurement, analysis) but also to conduct skilled consultations and negotiations among the many interested parties. Open, honest, and frequent communication among several agencies and facilities maximized our opportunity to reflect their thinking in program planning and meet their needs as they defined them in such plans.

Just as in Skillstreaming itself, in which trainee motivation is enhanced when the skill curriculum is negotiated with the trainee, staff motivation to participate in program procedures and implement them is enhanced when major aspects of the program are negotiated. Such a planning strategy need not negate research requirements such as standardization of intervention procedures nor disturb randomness of assignment to a particular condition. However, it does provide all interested parties with a genuine sense of participation in program planning and a shared ownership of program outcomes.

Training, Monitoring, and Supervision

Program integrity, defined as the degree to which program implementation is faithful to, consistent with, or corresponds to the program plan, is primarily a function of three related management activities—training, monitoring, and supervision. In each of the studies described, we initiated these functions by distributing to the staff at the participating agencies copies of the training process manual, *Aggression Replacement Training* (Goldstein & Glick, 1987). This manual describes all ART procedures and their implementation in a highly comprehensive, stepwise, concrete manner. We urged the staff to read and reread this manual prior to the next step in the training process: the trainer's workshop. Here, all staff of the participating agencies underwent an intensive, participatory, experiential series of lessons in the actual conduct of ART groups. These workshops also gave the project manager the opportunity, based on overt displays of ART-relevant competence and incompetence, to select from among the workshop participants those staff members who actually serve as project trainers. The workshops also enabled the project managers to determine which of the ART staff members were most able and willing to lead.

Once each project's ART sessions with participating juveniles actually began, we initiated an ongoing process of regular monitoring and supervision. This process took several forms, depending partly on the physical distance of the facility or agency from which the project managers were located, but also on the competence levels of particular trainers. We accomplished such monitoring and supervision by regular visits to the training sites where we observed ART sessions in progress and met with the group facilitators afterwards to offer feedback. We supplemented this on-site supervision by requiring trainers to keep weekly session notes, which they mailed to the managers for feedback. We held twice weekly (and often lengthy) telephone conversations. Most of the latter were regularly scheduled, but some occurred on an as-needed basis as issues or crises arose.

248

Perhaps the most valuable feature of this multipronged training, monitoring, and supervision process was the opportunities it provided not only to point out and correct intervention delivery "errors" (trainer behaviors departing from ART manual procedures), but also the chances it offered to "catch trainers being good." Trainers, as the participating juveniles themselves, are often especially deserving of recognition and praise for skilled enactment of training procedures. Unfortunately, trainers often do not receive this recognition, although it helps to maintain and improve performance.

Each of the two evaluations of ART in residential settings lasted a year. Each of the community and gang ART evaluations lasted two years. How do research managers keep staff trainers interested, involved, and true to intervention procedures as planned during such extended periods? The ART programs offered to participating juveniles within these respective programs were 20 to 32 sessions long, conducted on a twice-a-week basis. How do trainers keep juveniles with short attention spans, most of whom have found antisocial behavior to be consistently rewarding, interested and motivated to attend, participate in, and use the lessons of an intervention designed to teach prosocial alternative behaviors?

Our first answer to these often daunting questions is, "It ain't easy!" It was our clear sense in the management of this and other research programs that satisfactory program initiation was conducted much more easily than was satisfactory program maintenance. At launch time, all are excited and eager to "travel" several miles down the road. However, when implementation feels routine, novelty has long since departed, and problems—both anticipated and unexpected—have arisen, continuing to be eagerly involved and rigorous in our application of intervention procedures can and does become problematic.

Maintaining Motivation

We used two classes of motivators—extrinsic and intrinsic. Extrinsic motivators are tangibles provided in advance of or following competent performance. For staff trainers—in the community and gang studies, but not the institutional studies in which it was not permitted—project grant monies were used to pay for participation. Juveniles were "paid" also, in all four studies, but they were not paid with money. Although we had wanted to offer them money for participation, the funding agency disallowed this request. Instead, we provided them with food; we also provided movie privileges when deserved; and we gave each juvenile a specially designed "Angerbuster" T-shirt, as well as other material reinforcers.

Intrinsic motivators-reinforcers inherent in the intervention itself, or intangibles associated with it—began early in each program's implementation. In the two residential studies, before the program began, we placed a series of posters throughout each facility proclaiming in one or another way to both juveniles and staff that ART was coming and that it would provide the juveniles a special opportunity if they participated. For staff, as noted earlier, program participation also was preceded by motivation-enhancing involvement in program planning and decision making. This provided them with a sense of program ownership. As the program developed, for many staff the primary intrinsic motivators became their enhanced sense of professional competence and their enhanced belief that they were significantly intervening for the better in the lives of some very troubled juveniles.

For the juveniles themselves, intrinsic motivation followed primarily from their growing sense that the skills they were learning were, in fact, relevant and functional in their everyday lives in the facility, on the street, at school, and at home. We promoted such skill relevance and function, especially after the initial 10 weeks of the program was completed, by regular use of "negotiating the curriculum." Rather than, for example, beginning each Skillstreaming session with a staff member modeling a skill that he or she had selected, staff members were asked to engage the juveniles in a brief discussion of their current life events and concerns, and the skill to be taught was mutually selected from that discussion. Thus, a juvenile recently fired from his job in a fast food outlet for telling his boss to "shove it" may profitably choose to learn, and be taught the skill "Standing Up for Your Rights." The shy juvenile, wanting to reach out to an opposite sex peer but afraid to do so, will become more motivated to remain in the group and learn its lessons if he or she is taught "Starting a Conversation" and uses it effectively with that peer.

Finally, as both folklore and several hundred studies of the consequences of positive reinforcement make clear, for both the staff trainers and trainees, "catching them being good" was our most consistently effective motivation maintainer. For staff, such praise following competent skill use (or role-playing, homework completion, or dilemma discussion) regularly appeared to promote the desire for them to continue their involvement in program activities.

Data Collection and Analysis

In operational terms, evaluating the efficacy of ART was a multistage process. While reflecting the primary goal of standardization across conditions and studies, we also had to be responsive to the realities of the participating agencies and institutions. Even given realities, such as staff schedules, other juvenile programs in operation, security needs, and confidentiality needs, data collection proceeded in a generally "as planned" manner in all four program studies.

The specific management requirements constituting this aspect of the program included the following:

- Developing and selecting appropriate evaluation measures.
- Duplicating and disseminating measures to study sites.

- Instructing site staff in measurement administration.
- Preparing a measurement schedule.
- Administering tests to participating juveniles and staff as scheduled and in a standardized manner.
- Scoring and recording of the measures thus administered.
- Conducting appropriate data analyses.

Although we had our share of missing answers, participants who did not show up, last-minute scheduling changes, and similar events, the procedures and contents of the measurement effort remained intact. Our broad conclusion from collective study findings, as well as the several application innovations noted earlier, is that ART is a viable intervention for the management and reduction of adolescent and child aggression. We urge its continued use and evaluation.

References

Arbuthnot, J., & Gordon, D. A. (1983). Moral reasoning development in correctional intervention. *Journal of Correctional Education*, *34*, 133-38.

Coleman, M., Pfeiffer, S., & Oakland, T. (1991). *Aggression replacement training with behavior disordered adolescents*. Unpublished manuscript, University of Texas.

Curulla, V. L. (1990). *Aggression replacement training in the community for adult learning disabled offenders*. Unpublished manuscript, University of Washington.

Feindler, E. L., Marriott, S. A., & Iwata, M. (1984). Group anger control training for junior high school delinquents. *Cognitive Therapy and Research*, 8, 299-311.

Gibbs, J. (1999). Moral reasoning training. In A. P. Goldstein (Ed.), *The prepare curriculum* (pp. 323-415). Champaign, IL: Research Press.

Goldstein, A. P., & Glick, B. (1987). *Aggression replacement training*. Champaign, IL: Research Press.

Goldstein, A. P., Glick, B., Irwin, M. J., Pask-McCartney, C., & Rubama, I. (1989). *Reducing delinquency: Intervention in the community*. New York: Pergamon Press.

Goldstein, A. P., Glick, B., Carthan, M., & Blancero, D. (1994). *The prosocial gang: Implementing aggression replacement training*. Thousand Oaks, CA: Sage Publications.

Goldstein, A. P., Sprafkin, R., Gershaw, J., & Klein, P. (1980). *Skillstreaming the adolescent*. Champaign, IL: Research Press.

Jones, Y. (1990). *Aggression replacement training in a high school setting*. Unpublished manuscript. Center for Learning and Adjustment Difficulties, Brisbane, Australia.

Kellner, H., & Bry, B. H. (1999). The effects of anger management groups in a day school for emotionally disturbed adolescents. *Adolescence*, *34*, 645-651.

Kohlberg, L. (1969). Stage and sequence: The cognitive-developmental approach to socialization. In D. A. Goslin (Ed.), *Handbook of socialization theory and research*. Chicago: Rand McNally.

Kohlberg, L. (Ed.). (1973). *Collected papers on moral development and moral education*. Cambridge, MA: Harvard University, Center for Moral Education.

Leeman, L. W., Gibbs, J. C., Fuller, D. (1991). *Evaluation of multi-component treatment program for juvenile delinquents*. Unpublished manuscript. Ohio State University.

Maltz, D. (1984). *Recidivism*. New York: Academic Press.

Masias, C., & Anicama, J. (1995). Experiences en la applicacion de programa preventivo y de sustitucion de la violencia: El programa Art. En *Drogas, violencia y ecologia*. Lima, Peru: Cedro.

McGinnis, E., & Goldstein, A. P. (1984). *Skillstreaming the elementary school child*. Champaign, IL: Research Press.

McGinnis, E., & Goldstein, A. P. (1990). *Skillstreaming in early childhood*. Champaign, IL: Research Press.

Meichenbaum, D. (1977). *Cognitive behavior modification: An integrative approach*. New York: Plenum.

Nodarse, M. (1998). The effects of Aggression Replacement Training on adolescents with an emotional handicap. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 58, 6242.

Novaco, R. W. (1975). *Anger control: The development and evaluation of an experimental treatment*. Lexington, MA: Lexington Books.

Nugent, R., Bruley, C., & Allen, P. (1999). The effects of Aggression Replacement Training on male and female antisocial behavior in a runaway shelter. *Research on Social Work Practice*, 9, 17-34.

Zimmerman, D. (1983). Moral education. In A. P. Goldstein, (Ed.), *Prevention and control of aggression*. New York: Pergamon Press.

Appendix

Aggression Replacement Training Core Curriculum

Week	Skillstreaming	Moral Reasoning	Anger Control
1.	**Expressing a Complaint**		**Introduction**
	1. Define what the problem is and who's responsible for it.	1. The used car	1. Rational presentation and discussion
	2. Decide how the problem might be solved.	2. The dope pusher	2. Rules: presentation and discussion
	3. Tell the person what the problem is and how it might be solved.	3. Riots in public places	3. Training procedures: presentation and discussion
	4. Ask for a response.		4. Contract for anger control training, initial history taking
	5. Show that you understand his or her feelings.		5. Antecedent provocations-behavioral response-consequences (A-B-C)
	6. Come to an agreement on the steps to be taken by each of you.		
2.	**Responding to the Feelings of Others (Empathy)**		**Assessment**
	1. Observe the other person's words and actions.	1. The passenger ship	1. Hassle log: purpose and mechanics
	2. Decide what the other person might be feeling and how strong the feelings are.	2. The case of Charles Manson	2. Anger self-assessment: physiological cues
	3. Decide whether it would be helpful to let the other person know you understand his or her feelings.	3. LSD	3. Anger reducers: Reducer 1: deep breathing training; Reducer 2: backward counting; Reducer 3: peaceful imagery

Week	Skillstreaming	Moral Reasoning	Anger Control
2.	**Responding to the Feelings of Others (Empathy)**		**Assessment**
	4. Tell the other person, in a warm and sincere manner, how you think he or she is feeling.		
3.	**Preparing for a Stressful Conversation**		**Triggers**
	1. Imagine yourself in the stressful situation.	1. Shoplifting	1. Identification of provoking stimuli: a. Direct triggers (from others); b. Indirect triggers (from self)
	2. Think about how you will feel and why you will feel that way.	2. Booby trap	2. Role-play: triggers + cues + anger reducer
	3. Imagine that other person in the stressful situation. Think about how that person will feel and why.	3. Plagiarism	3. Review of hassle logs
	4. Imagine yourself telling the other person what you want to say.		
	5. Imagine what he or she will say.		
	6. Repeat the above steps using as many approaches as you can think of.		
	7. Choose the best approach.		

BEST COPY AVAILABLE

Appendix continued on p. 246

Appendix continued

Week	Skillstreaming	Moral Reasoning	Anger Control
4.	**Responding to Anger**		**Reminders (Anger Reducer 4)**
	1. Listen openly to what the other person has to say.	1. Toy revolver	1. Introduction to self-instruction training
	2. Show that you under stand what the other person is feeling.	2. Robin Hood case	2. Modeling use of reminders under pressure
	3. Ask the other person to explain anything you don't understand.	3. Drugs	3. Role-play: triggers + cues + reminders + anger reducer
	4. Show that you under stand why the other person feels angry.		4. Homework assignment and review of the hassle log
	5. If it is appropriate, express your thoughts and feelings.		
5.	**Keeping Out of Fights**		**Self-Evaluation**
	1. Stop and think about why you want to fight.	1. Private country road	1. Review of reminder homework assignment
	2. Decide what you want to happen in the long run.	2. New York versus Gerald Young	2. Self-evaluation of postconflict reminders: a. Self-reinforcement techniques; b. Self-coaching techniques
	3. Think about other ways to handle the situation besides fighting.	3. Saving a life	3. Review hassle log postconflict reminders
	4. Decide the best way to handle the situation and do it.		

Week	Skillstreaming	Moral Reasoning	Anger Control
6.	**Helping Others**		**Thinking Ahead (Anger Reducer 5)**
	1. Decide if the other person might need and want your help.	1. The kidney transplant	1. Estimating future negative consequences for current acting out
	2. Think of the ways you could be helpful.	2. Perjury	2. Short-term versus long-term consequences
	3. Ask the other person if he or she needs and wants your help.	3. Misrepresentation	3. Worst to least consequences 4. Role-play: "If … then" thinking ahead
	4. Help the other person.		5. Role-play: triggers + cues + reminders + anger reducers + self-evaluation + Skillstreaming skill
7.	**Dealing With Accusation**		**The Angry Behavior Cycle**
	1. Think about what the other person has accused you of.	1. Lt. Berg	1. Review of hassle logs
	2. Think about why the person might have accused you.	2. Perjury	2. Identification of own anger-provoking behavior
	3. Think about ways to answer the person's accusations.	3. Doctor's responsibility	3. Modification of own anger-provoking behavior
	4. Choose the best way and do it.		4. Role-play: triggers + cues + reminders + anger reducers + self-evaluation + Skillstreaming skill
8.	**Dealing With Group Pressure**		**Full Sequence Rehearsal**
	1. Think about what the other people want to do and why.	1. Noisy child	1. Review of hassle logs
	2. Decide what you want to do.	2. The stolen car	2. Role-play: triggers + cues + reminders + anger reducers + self-evaluation + Skillstreaming skill
	3. Decide how to tell the other people what you want to do.	3. Discrimination	

Appendix continued on p. 248

Appendix continued

Week	Skillstreaming	Moral Reasoning	Anger Control
8.	**Dealing With Group Pressure**		**Full Sequence Rehearsal**
	4. Tell the group what you have decided.		
9.	**Expressing Affection**		**Full Sequence Rehearsal**
	1. Decide if you have good feelings about the other person.	1. Defenses of other persons	1. Review of hassle logs
	2. Decide whether the other person would like to know about your feelings.	2. Lying in order to help someone	2. Role play: triggers + cues + reminders + anger reducers + self-evaluation + Skillstreaming skill
	3. Decide how you might best express your feelings.	3. Rockefeller's suggestion	
	4. Choose the right time and place to express your feelings.		
	5. Express affection in a warm and caring manner.		
10.	**Responding to Failure**		**Full Sequence Rehearsal**
	1. Decide if you have failed.	1. The desert	1. Review of hassle logs
	2. Think about both the personal reasons and the circumstances that have caused you to fail.	2. The threat	2. Role-play: triggers + cues + reminders + anger reducers + self-evaluation + Skillstreaming skill
	3. Decide how you might do things differently if you tried again.	3. Drunken driving	
	4. Decide if you want to try again		
	5. If it is appropriate, try again, using your revised approach.		

BEST COPY AVAILABLE

13

危
機

Identifying Troubled Youth

Sharon Lewis, M.A.
Lodi Unified School District (Lodi, CA)

Stephen E. Brock, Ph.D.
California State University, Sacramento

Philip J. Lazarus, Ph.D.
Florida International University

Recent highly publicized acts of school violence, committed by troubled youths, have shaken the belief that schools are safe. It is important to acknowledge, however, that the rates of school crime and serious offenses committed by juveniles peaked in the early 1990s and appear to have steadily declined since (Snyder & Sickmund, 1999). Current statistics suggest the odds that a student might die in school, by homicide or suicide, to be less than one in one million (U.S. Department of Education & U. S. Department of Justice, 1999). In fact, it has been reported that a child is three times more likely to be killed by lightning than to die as a victim of school violence (Hyman & Snook, 2000). Even though it can be argued that school is one of the safest places for our young people, one act of student violence is one too many. Thus, there remains an ongoing need for schools to be able to identify, and intervene with, potentially violent youths. Highlighting the promise of such early identification and intervention is the observation that before virtually all of most dramatic acts of school violence (e.g., Littleton, Colorado; Springfield, Oregon), warning signs were available to families, friends, school, and/or communities (Mohandie, 2000; Vossekuil, Reddy, Fein, Borum, & Modzeleski, 2000).

Violence directed toward others is only part of the problem. Suicide ranks as the third leading cause of death in the 15- to 24-year-old age group. Although the base rate for completed adolescent suicide is low (at 13.8 per 100,000; National Center for Health Statistics, 1996), completed suicides for youths rose 245% between the mid-1950s and mid-1990s (Peters, Kochanek, & Murphy, 1998). In addition, Miller and

Glinski's (2000) review of several large general population studies reports rates of adolescent suicide attempts at 7 to 16% of the adolescent population. Thus, there is also a need for our schools to be able to identify, and intervene with, potentially suicidal youths. Highlighting the promise of such early identification and intervention is the fact that the vast majority of adolescent suicide attempters do not become suicide victims (Ramsay, Tanney, Tierney, & Lang, 1996). Moreover, reports of comprehensive intervention programs in schools have suggested that, if students are identified while in school, suicide can be prevented. In a study of youths in Miami-Dade County Public Schools, Zenere and Lazarus (1997) report that not one youth who was identified as suicidal during a five-year period later committed suicide.

In this chapter we will define "troubled youth" and explore how early identification and treatment of these young people can minimize school crisis events. Most importantly, we will emphasize effective strategies for addressing the problems generated for schools by troubled youths. We then review a model prevention/intervention program. Finally, we offer ethical considerations and suggestions for future research.

Troubled Youth

Our definition of troubled youth focuses on students who are at risk for violence toward themselves (i.e., suicide) or others (i.e., homicide). These students require either secondary or tertiary mental health intervention in their schools and/or through collaborative efforts with community mental health professionals. Further clarification of the term "troubled youth" can be found in the Surgeon General's Report on Youth Violence (U.S. Department of Health and Human Services, 2001). This report presents risk factors (both personal characteristics and social conditions) that predict youth violence. In the primary grades, these factors include: (a) being male; (b) substance abuse; (c) aggression; (d) low intelligence; (e) antisocial parents; (f) poverty; (g) psychological conditions such as hyperactivity; (h) weak social ties; (i) antisocial behaviors, attitudes, beliefs, and peers; (j) exposure to TV violence; (k) poor school performance; (l) abusive parents; (m) poor parent-child relationships; and (n) broken homes. In addition to those just mentioned, in the secondary grades, risk factors include: (a) crimes against persons, (b) family conflict, (c) academic failure, (d) physical violence, (e) neighborhood crime, (f) gang membership, (g) risk-taking behavior, and (h) poor parental monitoring.

Regarding the most extreme forms of youth violence, Borum (2000) offers specific characteristics or risk factors for youths who commit murder. From the work of Garbarino (1999) and Zagar, Arbit, Busch, and Hughes (1990), Borum reports that a boy's chances of committing murder are twice as high if he: comes from a family with a history of criminal violence, has a history of being abused, belongs to a gang, and abuses alcohol or drugs. The odds triple when, in addition to the aforementioned risk factors, he: uses a weapon, has been arrested, has a neurological problem that impairs thinking and feeling, and has difficulties at school and has a poor attendance record. Garbarino (1999) makes the important point that risk threats accumulate. The presence of only one or two risk factors does not disable the child. It is the accumulation of threats that does the damage. He makes this analogy: Risk threats are like juggling tennis balls. Juggling one or two balls is easy, but juggling four or five is almost impossible. Moreover, as risk threats accumulate, a youngster's intellectual ability also suffers. For example, it was found that 11-year-olds with two or less risk factors had above average intelligence, whereas those with four or more risk factors had below average ability (Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987).

In addition, Davis and Brock (2002) offer specific characteristics of youths who commit suicide. These factors include: a history of psychiatric disorders and/or prior suicide attempts; a family history of suicide and/or medical and psychiatric illness; and economic stress, significant family strife, and family loss. When combined with the above risk factors, a variety of situational factors such as interpersonal loss or conflict (particularly in romance), economic problems, and legal problems are also associated with suicidal youths. In understanding the causes of homicide or suicide, it is necessary to underscore the importance of risk accumulation. Trying to find *the one* cause of extreme violence or suicide is not possible.

Targeted Violence Versus General Violence

Targeted violence has been conceptualized as violence in which the perpetrator and the target(s) are identified or identifiable prior to an incident (Borum, Fein, Vossekuil, & Berglund, 1999). The U.S. Secret Service uses this term when referring to individuals who make planned attacks against others. As noted earlier, identifiable risk factors are associated with violent behavior both in childhood and adolescence (U.S. Department of Education & U.S. Department of Justice, 1999). However, it has been suggested that students at risk for targeted violence may or may not possess many of the traditional risk factors associated with delinquency and general violence (Reddy et al., 2001). Based on the research of Cornell (1990), Reddy et al. report that juveniles who committed homicide were *less* likely to have had problems with school adjustment, *less* likely to have prior mental health difficulties, *less* likely to have prior arrests or placement in juvenile detention facilities, and *less* likely to have histories of prior violent behavior than were those youths convicted of assault. In addition, those youths who were perpetrators of school shootings (i.e., targeted violence) may differ from individuals who commit different types of homicide as well as from those who engage in nonviolent delinquency. Nonetheless, by our definition all these youths may be referred to as troubled.

School Crisis Events Minimized by Early Identification and Treatment

School Violence

School violence exists along a continuum ranging from teasing, to harassment or bullying (that includes both verbal and physical aggression), to homicide. As troubled youths at risk for such acts are identified and provided mental health treatment, the incidence of acts of violence will decline. School staff should be trained to spot potential warning signs of school violence and be provided with intervention options. A formal procedure to refer potentially violent students should be in place.

Student Suicide

Troubled youths often internalize problems, which can cause anxiety, depression, and suicidal ideation. School staff should be trained to spot warning signs of suicide and informed of their duty to intervene when suicidal ideation is observed or suspected. As troubled youths at risk for such acts are identified and provided mental health treatment, the incidence of school crisis events, such as student suicide, will decline. In addition, it is important to note that suicide risk assessment is also important to other directed violence threat assessment. According to the U.S. Secret Service's study of 37 cases of targeted school shootings, almost three-quarters of the attackers either threatened to kill themselves, made suicidal gestures, or tried to kill themselves before their acts of violence (Vossekuil et al., 2000).

Effective Strategies

The discussion that follows makes use of Caplan's (1964) three-part model of preventative mental health. First, we discuss primary prevention, which are actions aimed at "lowering the rate of new cases of mental disorders in a population over a certain period by counteracting harmful circumstances before they have a chance to produce illness" (p. 26). Next, we discuss secondary prevention activities. These interventions attempt to reduce the rate of mental disorders "by shortening the duration of existing cases through early diagnosis and effective treatment" (p. 89). Finally, we examine tertiary prevention interventions. These are interventions designed to rehabilitate troubled youths. The goal is to reduce "the impairment which may result from those [mental] disorders" (p. 17).

Primary Prevention

This section focuses on strategies to prevent troubled youths from becoming "troubled" in the first place. In this section, we discuss schoolwide or curricular approaches and the importance of mental health resources and resource development.

Schoolwide or Curricular Approaches

Schoolwide or curricular approaches help to provide an environment that develops and nurtures emotional healthy students (and thus prevents youths from becoming troubled). We will not discuss this topic in detail because several other chapters in this book address this topic in depth. The reader is referred to Chapter 4 (Creating Nurturing Classroom Environments: Fostering Hope and Resilience as an Antidote to Violence), Chapter 8 (Promoting Social Skills and Development of Socially

Supportive Learning Environments), Chapter 9 (Bullying in Schools: A Review of Prevention Programs), Chapter 10 (Peer Mediation and Conflict Resolution), and Chapter 12 (Aggression Replacement Training). However, we do want to pay special attention to two primary-grade prevention programs.

Second Step. This program is a primary intervention program that both research (Beland & White, 1993; Drug Strategies, 1998; Grossman et al., 1997; U. S. Department of Education & U. S. Department of Justice, 1998) and our experiences have found to be extremely effective in reducing the incidence of troubled youths. The goal of this structured and systematic curriculum is to foster socioemotional development and school adjustment of children through the development of empathy, impulse control, and anger management. Curricula are available for preschool through eighth grade.

The Primary Mental Health Project. This program is another example of a primary intervention program. The Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999) highlighted this project as a highly effective intervention program. A review of more than 30 program evaluation studies provides research data supporting the effectiveness of this program (Cowen et al., 1996). This research has found student participation in the project to be associated with significant improvements in student achievement scores, grades, and teacher ratings of school adjustment. By identifying, and intervening with, students at risk for developing school adjustment difficulties, this 44-year-old project aims at preventing young children from becoming "troubled." In our work as school psychologists, we have found this program to be simple and easy to implement. By making use of a specially trained paraprofessional, it provides special adult attention (via child-centered play) to young students judged by teachers as being at risk for school adjustment difficulties. This special attention gives students an unequivocally positive experience with an adult at school. Several state legislatures have provided funding for the systematic implementation of this program. For example, in California, a Primary Intervention Program is made available by State Department of Mental Health grants (through its Early Mental Health Initiative).

Availability and Development of School Mental Health Resources

A second primary prevention strategy is increased availability of school mental health resources. In 1992, the National Association of School Psychologists (NASP) recommended a ratio of 1 school psychologist per 1,000 students (American School Health Association, 1999; Fagan, 1995). Based on statistics of the prevalence of mental disorders in children and adolescents, there is a clear need to increase psychological services in schools. The Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999) estimates that 11% of U.S. children ages 9 to 17 have a diagnosable mental or addictive disorder resulting in significant functional impairment. These statistics suggest that virtually any school staff member may need to provide mental health services. As a result, there is a critical need for in-service training in this area (Doll, 1996).

From our experiences, we know that training in suicide risk identification and intervention is essential. Given the limitations of school mental health resources, it is important that all school staff members know how to identify suicide risk and offer "first aid" suicide intervention. The Suicide Intervention Workshop (Ramsey et al., 1996) is an example of an excellent program that teaches skills in how to identify and intervene with suicidal youths.

Another critical staff development area is responding to disruptive and/or acting-out youths. One training program we recommend is Nonviolent Crisis Intervention (Steiger, 1987). This program offers training in managing disruptive and assaultive student behavior. It gives special attention to the development of de-escalation skills to help prevent disruptive youths from becoming violent.

Secondary Prevention

It needs to be recognized that, despite the best of primary prevention efforts, students will likely continue to develop mental health problems that will lead to other- and self-directed violence. Thus, schools must be prepared to identify, refer, and intervene with these students as early as possible. In this section, we discuss risk assessment strategies designed to identify students at risk for violence. In addition, we review early interventions for these troubled youths.

Development and Implementation of Risk Assessment and Referral Strategies

All school staff members must be trained to identify the warning signs of potentially troubled youths. Resources for such staff development are reviewed by Brock, Sandoval, and Lewis (2001, pp. 254-258). Within schools, there has been a recent trend to use these warning signs as behavior profiling tools. The goal of such profiling is to help identify youths who present a serious danger. There are two general categories of behavioral profiling techniques: inductive and deductive profiling (Nelson, Roberts, Smith, & Irwin, 2000). Inductive profiling involves examining student behavior patterns to predict violent behavior before it occurs. MOSAIC-2000 (de Becker, 1999) is an example of a computer-assisted inductive profiling tool. Deductive profiling is a process of examining criminal evidence after the fact to understand motivations, attributes, and behavioral patterns of those who have committed crimes.

In applying FBI profiling principles to school shootings, McGee and DeBernardo (1999) reviewed 14 incidents of school violence to develop the "Classroom Avenger" profile. It is important to acknowledge that the application of profiling to prevent school violence and respond to threats has been criticized as ineffective and as having the potential to unjustly stigmatize students (Borum, 2000; Cooper, 2000; Sewell & Mendelsohn, 2000). Criticism has focused on concerns that the information may result in discrimination, invasion of privacy, punishment, isolation, and exclusion from school and activities without due process (rather than as a tool for identifying youths in need of intervention). Many experts have urged caution regarding use of warning signs and behavioral profiling (Borum, 2000; Dwyer, Osher, & Warger, 1998; Nelson et al., 2000). While these signs might in some cases predict violent behavior, they are not perfect. Dwyer et al. (1998) provide principles to avoid misuse of warning signs of violence. They advocate: (a) *do no harm* (keep information confidential and use signs to identify the need for interventions, rather than as a punishment tool), (b) *avoid stereotypes and labeling*, (c) *view student behavior within a developmental context, and* (d) *understand that many students show multiple signs and it is important not to overreact.*

In addition to training staff and students about warning signs of violence, a procedure should be developed for students, staff, and parents to refer troubled individuals for intervention and support. Once referred, the procedure must include provisions for risk assessment to determine the degree of risk. The procedure should designate a team to conduct risk assessments. A collaborative effort between site administration and school mental health professionals is recommended. If a moderate to serious risk of other-directed violence is suspected, law enforcement should be included in the evaluation and subsequent investigation. If a moderate to serious risk of self-directed violence is suspected, mental health personnel should be included in the evaluation.

U.S. Secret Service Threat-Assessment Model

Reddy et al. (2001) reviewed and critiqued three common approaches to risk assessment of targeted school violence. These approaches are behavioral profiling, guided professional or structured clinical assessment (including the use of warning signs and other checklists), and automated decision making (the use of actuarial formulas). Reddy et al. believe that these three approaches are inappropriate and even potentially harmful in preventing planned school-based attacks. These researchers explain that the common element in these approaches is that they are primarily inductive; that is, "they rely on aggregate information about prior events to guide inferences about facts in a specific case" (p. 167).

On the other hand, Reddy et al. (2001) note that threat assessment is the most promising approach to systematic risk assessment of troubled youths in schools. This approach focuses on the facts of a specific case, closely examines the progression of ideas and planning behavior over time, and corroborates information gained in a case through multiple sources (Borum, 2000; Reddy et al., 2001). The U. S. Secret Service developed this approach through the National Threat Assessment Center (NTAC). It is based on three guiding principles. First, there is no single type of perpetrator of targeted violence. Instead, targeted violence is perceived as the interaction of the perpetrator, the setting, the situation, and the target. Second, there is a distinction between posing a threat and making a threat. For example, many individuals who pose a threat will not make a threat before the attack. Conversely, many individuals who make a threat may pose no harm. Third, targeted violence is often a product of an understandable and often discernable pattern of behavior and thinking; that is, it is not random or spontaneous (Borum et al., 1999; Mohandie, 2000; Zinna, 2000). This last principle translates into an important point. If targeted violence is planned, then it may be preventable if caught before the plan takes effect.

The NTAC studied the behavior and thinking patterns of all 83 perpetrators known to have attacked, or attempted to attack, national leaders or public figures over a 50-year period (Borum et al., 1999; Fein, Vossekuil, & Holden, 1995). The NTAC conducted a similar study of 41 school shooters in 37 incidents in the hopes of gathering data that might be used to prevent such tragedies in the future (Vossekuil et al., 2000).

Threat-Assessment Approach for Evaluating Risk of Violence

Threat assessment is the process of identifying, assessing, and then managing individuals who pose a threat of targeted violence (Fein & Vossekuil, 1998). Table 1 summarizes the preliminary findings of the NTAC study (Vossekuil et al., 2000). Of particular interest are the findings that few attackers had been diagnosed with any mental disorder before the incident and less than one-third had histories of drug or alcohol abuse.

When students engage in specific behaviors that draw the attention and concern of others, suggesting the potential for violence and need for intervention, a threat assessment must be conducted. Tables 2 and 3, on pages 258-260, provide possible questions that may be useful in determining risk. The order and exact wording of the questions may vary to fit the developmental age of the student at risk. Such threat assessment must include an assessment of suicide risk. (For additional information on suicide risk assessment, refer to Chapter 26, Suicide Intervention.)

Fein and Vossekuil (1998) give suggestions for gathering data in a threat assessment. They recommend gathering preliminary information first, then interviewing the student at risk by focusing on his or her perceptions of events, followed by interviews of others to corroborate the story. Applied in a school setting, preliminary information can be gathered by a review of cumulative records and brief interviews with the student's current teacher or teachers. Subsequently, additional background information can be gathered by contacting other community agencies, including mental health, probation, and child protective services. After interviewing the student at risk, other persons who have contact with the student should be interviewed, including parents and family members, friends, and school staff. Another source of information is other students who have contact with the at-risk student. Recent writings, such as essays and journals, by the individual from class assignments should be reviewed for themes of depression, desperation, murder, suicide, and interest in weapons (this also would provide handwriting samples if needed later on in an investigation). When required, law enforcement investigation may include more extensive interviews of the student and others and may include searches of the student's possessions, home, and computer use, including e-mail and phone records.

An important principle of threat assessment is the distinction between making a threat (communicating intent to harm oneself or others) and posing a threat (engaging

Table 1

Summary of U. S. Secret Service Preliminary Findings on Targeted Violence in Schools

1. Incidents of targeted violence at school are rarely impulsive or the result of someone "snapping." The attacks are typically the result of a pattern of organized thinking and behavior.

2. Before most incidents, the attacker told someone, usually a peer, about the idea and/or plan.

3. There is no accurate or useful profile of "the school shooter." Characteristics of these individuals varied greatly. Violence is viewed as the interaction among the attacker, situation, target, and the setting.

4. Most attackers had previously used guns, although most did not necessarily demonstrate a "fascination" with weapons or explosives.

5. Most shooting incidents were not resolved by law enforcement intervention. More than half of the attacks ended before law enforcement arrival on scene. In these cases, staff or students stopped the attacker, the attacker stopped on his own, or he committed suicide. Half of the incidents lasted 20 minutes or less. Therefore, schools may make best use of their resources by focusing on prevention.

6. In most cases, other students were involved in some capacity, such as influencing or providing encouragement. In 75% of the cases, other students knew about the attack before it occurred in the form of either a vague idea something big was going to happen, and often the date and time or exact details.

7. In more than two-thirds of the cases, the perpetrator's history of having been bullied, harassed, threatened, or injured played a key role in the attack.

8. Most attackers engaged in some behavior before the incident that caused others to be concerned or indicated a need for help.

Note

From Vossekuil, Reddy, Fein, Borum, & Modzeleski (2000).

Table 2

Possible Questions for Threat Risk Assessment of Targeted School Violence

1. ***Identify possible stressors.*** What events are happening in your life right now that are stressful? What has happened in the past that was stressful? How have you coped with stress in the past? Have you had any major changes in your life lately (e.g., changes in living arrangements, loss of a significant relationship, death, divorce, a recent personal failure)?

2. ***Identify thoughts of revenge.*** Have any events happened where you felt you would like to get revenge or to get back at someone? Do you hold any grievances or bad feelings about school or individuals at school?

3. ***Identify experiences with/attitudes toward weapons.*** Do you have experience with guns? Do you have any experience with violent point and shoot video games?

4. ***Explore history of/attitudes toward violence.*** What are your views on violence? What do your parents think about violence? What do your friends think about violence? Do you have a history of violent behavior, criminal behavior, harassing others? Have you gathered any information about weapons, murders, suicides, or school shootings (e.g., Internet writings, news accounts, music, etc.)?

5. ***Identify signs of depression, helplessness, and/or hopelessness.*** Have you written any essays, poems, music, journals with themes of hopelessness, helplessness, homicide, and/or suicide? What kind of course do you feel your life is on right now: even, upward, or downward? Do you have feelings of depression now? Have you had feelings of depression in the past? For how long? How intense? Do you have feelings of being desperate?

6. ***Identify suicidal ideation.*** Have you ever tried to hurt yourself? Do you have any thoughts of hurting yourself or killing yourself now? Have you ever threatened to kill yourself? Have you ever made a gesture of suicide such as trying to slash your wrists? Have you tried to kill yourself before? Do you have a plan? (Ask "how," "how soon," and "how prepared.") Have you told others of your plans to kill yourself? What have been their reactions? What factors might increase the chance that you will attempt suicide? What factors might decrease the chance that you will attempt suicide?

7. ***Identify homicidal ideation.*** Do you have any thoughts of hurting or killing others now? Have you had any homicidal thoughts in the past? What plans do you

have? Have you taken any steps or actions to injure or kill others so far? What weapon(s) have you considered? Do you have access to guns (i.e., at home, at relatives)? Have you made any efforts so far to get hold of a gun(s)? Do you know how to get hold of a gun? Have you thought about whom you would target? Do you have a time and place in mind? Have you thought about how you would get close to this target (persons or building)? How well do you know the target? Have you thought of other targets? Have you thought of how to get around security measures? Have you told others of your plans to kill others? What have been their reactions? What factors might increase the chance that you will attempt to attack the target? What factors might decrease the chance that you will attempt to attack the target?

8. ***Explore motivations for violence.*** What are your motivations or reasons for planned violence? How do you think it would solve your problems? What other ways have you tried to solve your problems?

9. ***Identify additional psychiatric disorders.*** Have you had any hallucinations where someone is commanding you to do something? Have you had any delusional ideas, feelings that others are out to get you? Have you acted on these feelings or experiences? Do you have a history of mental illness? Does anyone in your family have a history of mental illness?

10. ***Identify possible helping resources.*** What do you need right now to make your life a little better? What has helped you cope with angry or depressed feelings in the past? How might the school help you? How might your family help you?

Note
Adapted from Borum (2000); Fein and Vossekuil (1998), and Vossekuil et al. (2000).

in behaviors that comprise a plan to harm oneself or others; Reddy et al, 2001). In the case of a direct threat of violence, the intent is often unclear. In some cases, the student may be joking, but all threats must be evaluated to determine if there is any risk of danger. Table 4, on page 261, summarizes possible motivations and intentions that may underlie such threats (Fein & Vossekuil, 1998; O'Toole, 2000). From the NTAC study of school shooters (Borum et al., 1999; Fein et al., 1995), we learned that it was infrequent (less than 25% of cases) for direct threats to be made to the intended victims; however, it was quite common (over 75% of cases) for school shooters to tell someone else, usually peers or siblings, of their ideas and/or plans (Vossekuil et al., 2000).

This last fact points out the need for schools to place efforts on teaching students, preferably starting at a young age, the difference between tattling (which involves telling on someone to get your own way or to get someone in trouble) and telling to keep someone from hurting themselves or others (Poland & McCormick, 1999). For further discussion of this issue, refer to Lazarus (2001).

Table 3

Possible Questions for Others Who Have Contact With a Student Suspected to be At Risk for Violence

1. ***For family and/or friends.*** Has *(name of student at risk)* told you of any ideas or plan to commit a violent act against the school? Against any specific person(s)? If so, describe these ideas/plans. Has *(student)* taken any steps to act on these ideas/plans?

2. ***For school staff, family and/or friends.*** How organized is *(name of student at risk)*? How capable do you think he/she is of acting on his/her ideas? How concerned do you think staff and family should be about the safety of the target(s)?

3. ***For identified target.*** How well do you know the student at risk of violence? How well does this person know your work and personal lifestyle patterns? What changes could make an attack less likely? How seriously do you take this threat of potential attack? How concerned are you about your safety?

Note
Adapted from Borum (2000); Fein and Vossekuil (1998), and Vossekuil et al. (2000).

The FBI Model

The FBI provides an alternative model of school threat assessment (O'Toole, 2000), which was developed by the FBI's National Center for the Analysis of Violent Crime (NCAVC). The model included input provided by the NCAVC 1999 Leesburg Symposium on school shootings and threat assessment (which was attended by select educators, administrators, mental health specialists, law enforcement officials, and prosecutors), most of whom had been involved in one of the school shootings. The FBI model differs from the U.S. Secret Service model in that the FBI uses more of a *trait-based* approach whereas the U.S. Secret Service uses a *behavioral* approach. The FBI also concluded that there is no typical profile of a school shooter. NCAVC's threat-assessment model recommends that all threats be reviewed in a timely manner through an established threat-assessment procedure and carried out by trained school staff. The purpose of the threat-assessment process is to determine the level of risk. Such determination is based on professional judgment and on answers to the following two questions: (a) How credible/serious is the threat? and (b) To what extent does the student making the threat have the resources, intent, and motivation to carry it out? NCAVC's threat-assessment model also proposes gathering data in the following four areas in order to make the risk assessment: (a) student personality (i.e., behavior characteristics and traits), (b) family dynamics, (c) school dynamics, and (d) social dynamics.

Table 4

Motivations: Reasons for Making Threats

- To warn of a possible attack.
- To ask to be stopped from pending violent acts.
- To assert power or control.
- To get revenge for an injury, slight, or injustice.
- To test authority.
- Reaction to fear of punishment or some other anxiety.
- To gain notoriety.
- To demand help or seek attention.
- To attempt to taunt or intimidate.
- To punish.
- To manipulate or coerce.
- To protect oneself.
- To express frustration or anger or to communicate distress.

Note
Adapted from Fein and Vossekuil (1998), and O'Toole (2000).

Determining the Level of Risk for School Settings

Mohandie (2000) suggests that examining how a student is evolving along five dimensions is the best way of integrating information regarding the potential for targeted violence. His method is consistent with the approach of the U.S. Secret Service and is beginning to be used by school systems such as Los Angeles Unified School District. He suggests assessing the extent to which the individual (a) is organized or disorganized, (b) is fixed on a particular idea or set of ideas, (c) is focused on a specific target, (d) demonstrates a violent action imperative, and (e) evidences a sense of urgency or time imperative.

Organized refers to whether the student is coherent, logical, and able to stick to themes or topics in verbal or written communication. Organized means that there is logic behind the person's thinking even if the ideas are frightening or even bizarre. In general, the more organized the person, the better his or her ability to engage in a purposeful, planned act of violence. It is more common for perpetrators of school violence to evidence organized thought processes because it usually requires organized planning to commit a school shooting.

Fixed describes a situation in which the following three conditions are present in verbal and written communication: (a) there are one or several themes, (b) blame is either implied or expressed, and (c) the blame is placed on issues that are important in the individual's life. The more fixed the theme of blame, the greater the risk.

Focused describes a person who: (a) identifies specific individuals, (b) believes that these individuals have harmed them, (c) attributes malevolent intent to their actions: and (d) wants these persons to be punished. Generally, the more focused the student is on either a target or targets, the greater the risk.

Violent action imperative deals with two conditions. First, the person perceives that legitimate ways of coping with his or her life circumstances have been exhausted or are inadequate. Second, the person evidences a willingness to take violent action to solve the difficulties. The more indicators that are consistent with this violent action imperative, the greater the risk.

Time imperative exists when the person indicates a short-term time frame for taking immediate action and expresses a sense of urgency for initiating any plans. The shorter the time imperative, the greater the risk. Evaluating time imperative is a useful way of guiding thinking when gathering information related to discussions, diary entries, e-mail, letters, and other forms of communication. In addition, evaluating time imperative is an important consideration in determining the necessity of having the youth taken into police custody or hospitalized.

Mohandie (2000) suggests that a threat-assessment team composed of an educator, mental health professional, school police or resource officer, and legal counsel (as necessary) conduct an assessment. The threat-assessment team members access collateral sources to identify warning signs, potential risk and stability factors, and precipitating factors as well as to determine how the individual is moving toward violence on the basis of the five aforementioned dimensions. Based on this information, at-risk individuals are assessed along a five-category continuum, from Category 1, High Violence Potential, Qualifies for Immediate Arrest or Hospitalization, to Category 5, Insufficient Evidence for Violence Potential or Emotional Distress Upon Others. Under threat-assessment models such as the one proposed by the FBI, a low-risk-level-threat is defined as one where the threat is vague, implausible, indirect, lacks details, information contains inconsistencies, and it appears unlikely the person will carry out the threat. A medium level of risk involves a threat that could be carried out, even though it may appear somewhat unrealistic. The threat is more direct and concrete with evidence of some thoughts of planning such as a possible time and place but no preparatory actions taken yet. A high level of risk in threat assessment involves a threat that poses imminent danger to the safety of self and/or others. Through these models, when a student's risk level is judged to be medium or high and the student appears to have serious problems in the majority of risk assessment areas and is moving toward a trajectory of violence, the seriousness of the threat is increased. Then, intervention by school authorities, mental health professionals, and/or law enforcement should occur immediately.

Preliminary Research Related to Threat Assessment in Schools

Threat assessment in schools is a recent phenomenon and there is limited published research on incidence data or effectiveness. Consequently, school districts are not able to understand the extent of the problem. The Dallas Independent School District developed a Dallas Violence Risk Assessment (DVRA) to evaluate students who have made verbal or written threats of violence and to assist school staff in determining appropriate intervention strategies (Ryan-Arredondo et al., 2001). The incidence data are particularly important to school districts. When a student makes a threat, the principal can handle it as a terrorist threat as defined by the Texas Penal Code or as a threat of a less serious nature. According to end-of-the-school-year data, in a district with approximately 160,000 students, the number of students who made a terrorist or other threat was 202, or 1.3 in 1,000. The number who made a terrorist threat was 77, or 0.5 in 1,000. More males (87%) than females (13%) made threats. Of those threats, 54% were secondary students versus 46% in elementary school. The grade with the highest number of threats was seventh grade. If these data can be generalized to other school districts, then there is some understanding of the extent of the problem. Trump (2000) has suggested that superintendents or school principals may believe that they will be perceived as poor managers if they acknowledge ongoing problems with violence. Perhaps this base rate data will be helpful in acknowledging threats of violence and spur willingness to take action.

Early Interventions

Responding to at-risk youths. It is recommended that school staff meet to review the needs of their at-risk students at least twice a year. One example of this approach involves a classroom teacher, principal, mental health specialist, and perhaps a master teacher meeting and reviewing student data for an entire class (with special attention directed toward academic and behavioral planning for the at-risk students). Table 5, on page 264 provides a protocol for responding to these at-risk youths. Once strategies are implemented, provisions must be made to monitor progress and, if no improvement is found, to modify these initial interventions. Usually, additional modifications will be developed in a review by a school Student Support or Student Assistance Team.

Responding to high-risk youths. A procedure also must be in place for the provision of immediate intervention whenever a youth is judged at high risk for acts of violence directed toward self or others. The imminent warning signs of violence, developed by Dwyer et al. (1998), are presented in Table 6, on page 265. When the safety of a student or others is in question, action by school administration must take place immediately, usually with involvement of a school-based mental health professional, to assess the level of risk for potential violence toward self or others. Additionally, Dwyer and Osher (2000) recommend an informal process to provide immediate support until a formal meeting may be scheduled for high-risk students. Table 7, on page 266, describes a protocol for responding to high-risk youths.

Table 5

Protocol for Responding to At-Risk Youth

1. Teacher and school staff meet to review the following student data for at-risk students: group achievement test scores, test scores from local district assessment measures, attendance records, discipline records, language proficiency status, and school history.
2. Teacher and staff analyze the academic instruction across subject areas and suggest modifications if needed.
3. Teacher, staff, parents, and student develop a behavior contract if needed.
4. Teacher, staff, parents, and student develop a plan to improve attendance if needed. Documentation of poor school attendance following prescribed district procedures are implemented and carefully monitored.
5. Provisions are made to teach appropriate behavior and social problem-solving skills in the classroom or in a small group setting.
6. Any additional problems or risk factors are addressed through determining student and family needs. Referrals are made to appropriate school and/or community support systems.
7. Protective factors for student are analyzed and provisions made to continue or to add to these factors, which provide support for the at-risk student. For example, provide an adult mentor who meets periodically with the student.

Note
Adapted from Dwyer and Osher (2000).

Tertiary Prevention

Tertiary prevention activities require a multiagency effort involving school districts, community mental health, law enforcement, probation, human services, and other agencies as needed. Working together, these agencies need to track troubled youths and ensure provision of long-term care. Multiagency "wrap-around" services should be used for such tertiary care. Through such a service approach, each agency considers what resources it has available to meet student and family needs, and then all agencies collaboratively develop an individualized intervention plan.

School mental health professionals should communicate closely with community-based mental health care providers. For example, school personnel need to know when treatment starts, how treatment is progressing, what can be done to provide support at

Table 6

Imminent Warning Signs of Violence

1. Serious physical fighting with peers or family members
2. Severe destruction of property
3. Severe rage for seemingly minor reasons
4. Detailed threats of lethal violence
5. Possession and/or use of firearms and other weapons
6. Other self-injurious behaviors or threats of suicide

Note
From Dwyer, Osher, and Warger (1998, p. 11). This document is in the public domain.

school, and when prescribed medications are changed. For youths who require hospitalization, it is important to plan transitions carefully (e.g., moving the student to a new treatment facility, back to his or her former school, a new school placement, or home instruction). Finally, close communication should occur between the school and the student's care providers (e.g., biological parents, social workers, guardians, and/or surrogate parents).

The U.S. Secret Service has made several recommendations to monitor, control, and redirect subjects at high risk for violent behavior (Fein & Vossekuil, 1998). First, it recommends giving a consistent and coordinated message to the student at risk for violence that an attack will not be permitted. In addition, special emphasis needs to be placed on communicating to the troubled youth that it is clearly not in anyone's best interest to engage in violent acts. These messages need to come from all agencies and institutions involved with the youth (e.g., law enforcement, school staff, the student's family and friends, probation, etc). Negative consequences for acts of violence should be identified and motivations for violence addressed. For example, if a violent act was planned as a means to escape personal pain, other options and solutions to escape the pain should be explored. Second, the U.S. Secret Service recommends making the troubled youth aware of any investigation that is taking place (unless there are valid reasons not to, such as a large numbers of suspects involved), and clearly communicating that violent behavior will be stopped. Third, Fein and Vossekuil recommend eliciting the subject's cooperation in being monitored by law enforcement. Regularly scheduled interviews need to be conducted and clear messages about unacceptable behavior must be delivered. Finally, it is recommended that the importance of mental

Table 7

Protocol for Responding to High-Risk Youth

1. Determine if there are any imminent warning signs. If there are, then refer the student to the Risk Assessment Team for an immediate suicide and/or homicide risk assessment.

2. If imminent warning signs are not present, then give the student a high priority for a Student Support Meeting. Assign a Student Support Team member (e.g., principal, mental health specialist, or master teacher) to provide informal consultation until a formal meeting may be scheduled.

3. At the formal meeting, develop recommendations for responding to high-risk youth and consider the need for a referral for special education services.

4. Consider a referral to school site mental health and community-based mental health services.

5. Consider the need to revise the student's behavior contract and/or to conduct a more in-depth behavioral analysis.

6. Obtain parental permission to exchange information with the appropriate community agencies to determine if the student is eligible for additional services. If available, call a meeting with other agency personnel to focus on provisions for wraparound intervention and support for the student and family.

7. Develop an action plan for immediate interventions that includes provisions for increased supervision.

Note
Adapted from Dwyer and Osher (2001).

health intervention be consistently reinforced by everyone (especially law enforcement) involved with the student.

Model Programs

A comprehensive model program for responding to troubled youths can be found in *Safeguarding Our Children: An Action Guide* (Dwyer & Osher, 2000). This program was developed as a follow-up to *Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer et al., 1998). It presents resources and programs to address troubled youths through three components: (a) providing a schoolwide foundation for all students through the use of prevention programs; (b) early intervention for some at-risk students, and (c) provisions for intensive services targeting high-risk students. One recommendation of the *Action Guide* is to employ two student support teams (with a principal, teacher, and mental health specialist serving on both). The first team is the schoolwide or management team, which makes decisions regarding schoolwide performance. The second is the team that addresses individual student problems. Dwyer and Osher also point out the importance of teaching appropriate behavior and social problem-solving skills to all students, creating a safe physical environment, and providing appropriate academic instruction.

An additional excellent resource reviewing primary, secondary, and tertiary prevention and intervention programs and strategies is found in the Surgeon General's Report on Youth Violence (U.S. Department of Health and Human Services, 2001). This report provides a discussion of model programs, promising programs, as well as programs and strategies that, while in widespread use, have been suggested by evaluation studies to be ineffective.

Ethical and Research Considerations

When identifying troubled youths, the first principle is do no harm. In identifying troubled students, the emphasis needs to be placed on getting the intervention needed so that the student can become a productive member of society. Identifying a student as at risk or potentially violent carries an enormous ethical responsibility. Yet, at the same time, if effective prevention approaches are implemented it also provides promise for the troubled youth. Consequently, more empirical research needs to be conducted on the effectiveness of prevention programs for at-risk or potentially violent students.

It has been shown that the ability of teachers (Mulvey & Lidz, 1995) and mental health professionals to accurately predict violence is limited (Borum, 1996). Nonetheless, some school districts have responded to school shootings by trying to identify *more* students at risk for violence. It is important that these districts do not overidentify or unnecessarily stigmatize a student. Furthermore, it has been suggested that students either identified or misidentified as at risk for violence have at times been targets of punitive discipline rather than violence-prevention approaches (Burns, Dean, & Jacob-Timm, 2001). This is an important ethical concern because some researchers have argued that the use of preventative discipline in response to potential violence can actually increase aggressive behavior and hostility (Hyman & Perone, 1998).

Different types of violence have different antecedents. Existing research on general violence of students and youths who commit homicide may not be applicable to targeted school violence. More knowledge about the antecedents, motives, communication, idea development, and planning behavior of perpetrators of targeted school violence needs to be gained in order to prevent school-based shootings (Reddy et al., 2001).

Presently, the threat-assessment approach appears to have promise. Nonetheless, how this model can be used effectively in schools needs to be determined. Future research must address issues such as training threat-assessment team members, the best composition of professionals on the team, and collaboration between different disciplines.

In addition, we know that students are often the first to hear about potential attacks in school. Research is needed to understand barriers that prevent students from informing a responsible adult about potential threats and to understand how to remove those barriers (Lazarus, 2001).

Summary

This chapter has provided a definition of "troubled youth" and offered discussion of efforts to minimize the school crises that may be generated by these students. Research on school violence indicates that schools make the best use of their resources by focusing on prevention and intervention. Primary prevention efforts focus on strategies that are designed to prevent youths from becoming "troubled" in the first place. An important strategy in this regard is to increase availability of school mental health resources. Secondary prevention efforts are designed to provide early intervention and treatment of troubled youths. Tertiary prevention activities include the long-term treatment and after-care our most troubled students require. Finally, the chapter reviewed school safety planning, offered ethical concerns, and suggestions for future research.

References

American School Health Association. (1999). *School health in America* (6th ed.). Kent, OH: Author.

Beland, K., & White, T. (1993). *Second step: A violence prevention curriculum*. Seattle, WA: Committee for Children.

Borum, R. (1996). Improving the clinical practice of violence risk assessment: Technology, guidelines, and training. *American Psychologist, 51*, 945-996.

Borum, R. (2000). Assessing violence risk among youth. *Journal of Clinical Psychology, 56*, 1263-1288.

Borum, R., Fein, R., Vossekuil, B., & Berglund, J. (1999). Threat assessment: Defining an approach for evaluating risk of targeted violence. *Behavioral Sciences and the Law, 17*, 323-337.

Brock, S., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Burns, M. K., Dean, V. J., & Jacob-Timm, S. (2001). Assessment of violence potential among school children: Beyond profiling. *Psychology in the Schools, 38*, 239-247.

Caplan, G. (1964). *Principles of preventative psychiatry*. New York: Basic Books.

Cooper, K. J. (2000, April 19). Riley rejects schools' profiling of potentially violent students. *The Washington Post*, p. A11.

Cornell, D. G. (1990). Prior adjustment of violent juvenile offenders. *Law and Human Behavior, 14*, 569-577.

Cowen, E. L., Hightower, A. D., Pedro-Carrol, J. P., Work, W. C., Wyman, P. A., & Haffey, W. G. (1996). *School-based prevention for children at risk: The primary mental health project*. Washington, DC: American Psychological Association.

de Becker, G. (1999). MOSAIC-2000. Available Online: www.gdbinc.com/mosaic2000.htm

Davis, J. M., & Brock, S. E. (2002). Suicide. In J. Sandoval (Ed.), *Handbook of crisis counseling, intervention and prevention in the schools* (2nd ed., pp. 273-299). Hillsdale, NJ: Earlbaum.

Doll, B. (1996). Prevalence of psychiatric disorders in children and youth: An agenda for advocacy by school psychology. *School Psychology Quarterly, 11*, 20-47.

Drug Strategies. (1998). *Safe schools, safe students: A guide to violence prevention strategies*. Washington, DC: Author.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education.

Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide*. Washington, DC: U.S. Departments of Education and Justice.

Fagan, T. (1995). Trends in the history of school psychology in the United States. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 59-67). Washington, DC: National Association of School Psychologists.

Fein, R. A., & Vossekuil, B. (1998, July). *Protective intelligence and threat assessment investigations: A guide for state and local law enforcement officials*. Washington, DC: U.S. Secret Service and U.S. Department of Justice.

Fein, R. A., Vossekuil, B., & Holden, G. A. (1995, September). Threat assessment: An approach to targeted violence. *National Institute of Justice: Research in Action*, pp. 1-7.

Garbarino, J. (1999). *Lost boys: Why our sons turn violent and how we can save them*. New York: The Free Press.

Grossman, D. C., Neckerman, H. J., Koepsell, T. D., Liu, P., Asher, K. N., Beland, K., Frey, K., & Rivara, F. P. (1997). Effectiveness of a violence prevention curriculum among children in elementary school. *Journal of the American Medical Association, 277*, 1605-1611.

Hyman, I., & Perrone, D. (1998). The other side of school violence. Educator policies and practices that may contribute to student misbehavior. *Journal of School Psychology, 36*, 7-27.

Hyman, I. A., & Snook, P. A. (2000, March). *Dangerous schools/dangerous students: Defining and assessing student alienation syndrome*. Paper presented at the National Association of School Psychologists annual convention, New Orleans, LA.

Lazarus, P. (2001, May). Breaking the code of silence: What schools can do about it. NASP *Communiqué, 29*(7), 28-29.

McGee, J., & DeBernardo, C. R. (1999, May/June). The classroom avenger: A behavioral profile of school based shootings. *The Forensic Examiner*, pp. 16-18.

Miller, A. L. & Glinski, J. (2000). Youth suicidal behavior: Assessment and intervention. *Journal of Clinical Psychology, 56*, 1131-1152.

Mohandie, K. (2000). *School violence threat management*. San Diego, CA: Specialized Training Services.

Mulvey, E. P., & Lidz, C. W. (1995). Conditional prediction: A model for research on dangerousness to others in a new era. *International Journal of Law & Psychiatry, 18*, 129-143.

National Center for Health Statistics. (1996). Advance report of final mortality statistics, 1994. *NCHS Monthly Vital Statistics Report, 45*, 63.

Nelson, R., Roberts, M., Smith, D., & Irwin, G. (2000, February). The trouble with profiling youth at-risk for violence. NASP *Communiqué, 28*(5), 10.

O'Toole, M. E. (2000). The school shooter: A threat assessment perspective. Quantico, Virginia: National Center for the Analysis of Violent Crime and Federal Bureau of Investigation Academy.

Peters, K. D., Kochanek, K. D., & Murphy, S. L. (1998). *Deaths: Final data, 1996. National vital statistics Report, 47*. Hyattsville, MD: National Center for Health Statistics. [DHHS Publication No. (PHS) 99-1120.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Ramsay, R. F., Tanney, B. L., Tierney, R. J., & Lang, W. A. (1996). *Suicide intervention workshop* (6th ed.). Calgary, AB: Living Works.

Reddy, M., Borum, R., Berglund, J., Vossekuil, B., Fein, R., & Modzeleski, W. (2001). Evaluating risk for targeted violence in schools: Comparing risk assessment, threat assessment, and other approaches. *Psychology in the Schools, 38*, 157-172.

Ryan-Arredondo, K., Renouf, K., Egyed, C., Doxey, M., Dobbins, M., Sanchez, S., & Rakowitz, B. (2001). Threats of violence in schools: The Dallas Independent School District's response. *Psychology in the Schools, 38*, 185-196.

Sameroff, A., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotients scores of 4-year-old children: Social environmental risk factors. *Pediatrics, 79,* 343-350.

Sewell, K. W., & Mendelsohn, M. (2000). Profiling potentially violent youth: Statistical and conceptual problems. *Children's Services: Social Policy, Research, and Practice, 3,* 147-169.

Snyder, H. N., & Sickmund, M. (1999). *Juvenile offenders and victims: 1999 national report.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Steiger, L. K. (1987). Participant workbook. *Nonviolent crisis intervention: A program focusing on management of disruptive, assaultive, or out-of-control behavior.* Brookfield, WI: National Crisis Prevention Institute.

Trump, K. S. (2000). *Classroom killers? Hallway hostages?: How schools can prevent and manage crises.* Thousand Oaks, CA: Corwin Press.

U.S. Department of Education & U.S. Department of Justice. (1998). *Annual report on school safety—October 1998.* Washington, DC: Authors.

U.S. Department of Education & U.S. Department of Justice. (1999). *1999 annual report on school safety.* Washington, DC: Authors.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health. Available Online: www.surgeongeneral.gov/library/mentalhealth/home.html

U.S. Department of Health and Human Services. (2001). *Youth violence: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health. Available Online: www.surgeongeneral.gov/library/youthviolence/report.html

Vossekuil, B., Reddy, M., Fein, R., Borum, R., & Modzeleski, W. (2000, October). *U.S.S.S. Safe School Initiative: An interim report on the prevention of targeted violence in schools.* Washington, DC: U. S. Secret Service, National Threat Assessment Center.

Zagar, R. Arbit, J., Busch, K. G., & Hughes, J. R. (1990). Homicidal adolescents: A replication. *Psychological Reports, 67,* 1235-1242.

Zenere, F. J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural school system following the introduction of a suicide prevention and intervention program. *Suicide & Life-Threatening Behavior, 27,* 387-403.

Zinna, K. A. (2000). *School violence prevention training manual.* Broomfield, CO: Author.

14

危機

School Crisis Preparedness

Stephen E. Brock, Ph.D.
California State University, Sacramento

Scott Poland, Ed.D.
Cypress-Fairbanks Independent School District (Houston, TX)

In 1992, Gayle Pitcher and Scott Poland suggested that school crisis intervention was still in its infancy. Given this developmental status it was not surprising that many early school crisis responses were reflexive in nature. Typically, very little planning, in advance of a crisis event, had taken place when schools responded to traumatizing circumstances. Although such reflexive responses may have been acceptable a decade ago, 21st century schools are expected to be better prepared to respond to crisis events.

Clearly, there is an increasing mandate for today's schools to be better prepared for the school crisis response. The public has come to expect crisis response following situational crises. In addition, a growing number of resources are available to assist schools as they prepare for crises.

Recognizing the increasing expectations for school crisis preparedness, this chapter's three sections will review this topic. It begins with a discussion of key terms, the need for crisis preparedness, and how crisis preparedness can be viewed as a form of crisis prevention. Next, it reviews several model crisis preparedness programs. Included in this discussion is an acknowledgment of the need for research. Finally, the chapter concludes with specific recommendations for crisis preparedness.

Defining School Crisis Preparedness

The first issue to consider when defining the term "school crisis preparedness" is to clarify what is meant by "crisis." In other words, what events are the focus of preparedness efforts? According to Brock, Sandoval, and Lewis (1996), the *situational crisis* is most commonly associated with the need for school crisis preparedness. Situational crises are events that are relatively rare, unexpected, unpredictable, have a sudden onset, and seem to strike from nowhere. They have an emergency quality and have the potential to affect an entire school community. Examples of these events include severe illness and injury, violent and/or unexpected death, threatened death and/or injury, acts of war, natural disasters, and man-made/industrial disasters (Slaikeu, 1990).[1]

It is the potential of a situational crisis to affect an entire school that results in the need for preparedness. Clearly, traditional school resources and personnel cannot sufficiently respond to a school population that has been traumatized by a crisis event. Thus, schools must have contingency plans in place for responding to crises that overwhelm available resources. With this definition of crisis in mind, the authors define school crisis preparedness as follows:

> School crisis preparedness activities are the actions undertaken by school personnel in anticipation of situational crises. These actions include the development of procedures designed to meet the needs of large numbers of students and staff members who have been physically and/or psychologically traumatized by a crisis. In addition to developing plans for responding to medical and psychological needs, crisis preparedness efforts also include provisions for ensuring school safety and security, managing and responding to the media, and debriefing and evaluating a crisis response.

The Need for Crisis Preparedness

As emphasized by the chapters at the beginning of this volume, much can be done to prevent crises from occurring. Unfortunately, despite the best prevention efforts, not all crises can be prevented. For example, it is impossible to stop natural disasters such as earthquakes. In addition, while much can be done to prevent school violence, it seems unlikely that we can protect our schools from all acts of random violence (Brock, 2002).

The importance of school crisis response preparedness cannot be understated (Brock, 2002). While it is impossible to prepare for all contingencies, crisis preparedness efforts place schools in the best possible position to respond to crises. The need for preparedness is reinforced by the fact that the school crisis response is multifaceted and typically includes a number of different activities (e.g., providing psychological first aid, working with the media, ensuring safety and security, responding to emergency medical and health needs, and evaluating and debriefing the crisis response). Crisis preparedness efforts help to ensure that none of these activities are overlooked in the chaotic times following a crisis. Crisis preparedness also helps to minimize crisis response service delays. The importance of an immediate response is especially acute when it comes to the provision of psychological first aid. The effectiveness of these services increases directly as a function of the intervention's proximity, in both time and place, to the crisis (Slaikeu, 1990).

Crisis Preparedness as a Form of Crisis Prevention

By facilitating an effective and efficient crisis response, crisis preparedness efforts might also be considered a form of crisis prevention. For example, by facilitating the

283

provision of psychological first aid to traumatized individuals, crisis preparedness helps to ensure adaptive coping and minimizes the risk of the psychological problems associated with crises (e.g., suicidal behavior).[2] The facilitation of adaptive coping may also result in greater resilience and an improved ability to face future life stressors. In addition, by considering medical emergency issues, such as where the deceased are placed and the injured are treated, crisis preparedness efforts may help to prevent the trauma associated with viewing frightening scenes of blood and carnage. Further, by facilitating media relations, crisis preparedness efforts may prevent sensationalism (which can increase the traumatizing potential of a crisis). Finally, by facilitating the reunification of students with their parents following crises, preparedness efforts may minimize the anxiety associated with parent-child separation.

Effective Strategies

Currently, a variety of resources are available to schools as they engage in crisis preparedness activities. From this literature, we have selected five books that are frequently used by school personnel. This section briefly reviews these resources. For additional information, the reader is encouraged to make each of these books a part of their own school crisis response library.

Crisis Intervention in the Schools (Pitcher & Poland, 1992)

This book, which was one of the first to explore the school crisis response, offers a comprehensive overview of school crisis preparedness. For example, the authors cite the importance of including transportation personnel and police, and call for more curriculum programs to reduce the leading causes of death for children.

Crisis theory. Pitcher and Poland draw heavily on the work of Slaikeu (1984) to outline a definition of crisis and to understand the basic principles of a crisis response. In addition, the authors organize the book according to Caplan's (1964) levels of prevention (i.e., primary, secondary, and tertiary prevention). Pitcher and Poland point out that few schools focus on preventing a crisis from occurring (primary prevention), but instead tend to focus primarily on the initial aftermath (secondary prevention).

Practical examples. The book includes discussion of a moving and tragic shooting at a high school in the school system where the authors worked. Pitcher and Poland point out how overwhelming the incident was to the whole community. The book outlines practical steps that were taken to assist the affected school and the entire community. The authors review many other crisis incidents (including major school shootings) that had occurred before the book's publication and they include many recommendations for crisis management.

Establishing a crisis team. From the work of Ruof and Harris (1988), Pitcher and Poland point out that school systems have three choices when forming a crisis team.

These choices are to create (a) a district team involving only personnel who work for the school district; (b) a community team involving school and nonschool personnel such as police, fire department, and medical or mental health personnel; or (c) a building team composed only of school personnel working in one building. Pitcher and Poland outline specifically how school systems can examine their own size and resources to determine which type of crisis team they need.

Pitcher and Poland also identify the following specific duties for crisis team members: counseling liaison, law enforcement liaison, media liaison, student liaison, parent liaison, medical liaison, and campus liaison. Lengthy examples of sample duties for each liaison are outlined according to Caplan's (1964) levels of prevention. Additionally, Pitcher and Poland discuss the desirable qualities of crisis team members and team training issues.

Crisis reactions of students. Pitcher and Poland provide an overview of the most common reactions youths have to crises by age (i.e., preschool, early childhood, preadolescent, and adolescent). The authors also provide recommendations to assist children that are specific to these age levels.

Crisis drills. Pitcher and Poland were among the first to stress the need for moving crisis drills beyond the traditional fire drill. They cite administrators who had dealt with school violence and who had stressed that all schools should prepare with drills. The authors outline the development of crisis drills in their school system and include examples. The duties of each liaison are outlined for each drill.

Appendices. Pitcher and Poland conclude their book with extensive appendices to assist the reader with training school personnel in all aspects of crisis intervention. It emphasizes a collaborative approach with all relevant school departments and local agencies. The book also includes a test that covers key points.

School Crisis Survival Guide (Petersen and Straub, 1992)

Offering "practical and realistic support in developing a crisis plan before a crisis strikes" (p. vii), is the goal of the *School Crisis Survival Guide*. Petersen and Straub's conceptualization of crisis preparedness includes discussion of crisis team development and the elements of a crisis plan.

Team development. Petersen and Straub recommend that before initiating a crisis plan, schools must first "select and assemble a team of qualified individuals" (p. viii). Specifically, they recommend the following team composition: Principal (and his or her alternate), counselor, faculty member, security officer, school psychologist, and nurse. The book delineates the functions and responsibilities of each member.

Like Pitcher and Poland (1992), Petersen and Straub also suggest there may be more than one level of crisis response. Specifically, they suggest using two levels of crisis response teams. For the first level, the system-wide crisis team, a school district develops one crisis response team that serves an entire district. For the second level, the in-house crisis team, a crisis team is assembled at each school site. Petersen and Straub were among the first to argue that both levels are important to crisis preparedness.

Plan development. To facilitate the development of a crisis plan, Petersen and Straub offer checklists that delineate the specific functions of each team member. In addition, they view this crisis preparedness task as including staff development and identifying community resources to help support the crisis response. Petersen and Straub view a prepared crisis team as having had experience dealing with crises, as knowing the crisis plan, and as being familiar with and knowing how to prevent post-traumatic stress disorder.

In their discussion of plan development, Petersen and Straub devote significant attention to preparations for working with the media. Their preparedness recommendations include the following: (a) build a relationship with the media in advance of a crisis, (b) set limits for the media (e.g., where they will be allowed), (c) identify a spokesperson, and (d) prepare written statements.

Crisis response. From their model crisis plan, Petersen and Straub delineate a specific crisis response protocol. According to this protocol, the first step in responding to crisis is to assemble the crisis team. The next step is to verify crisis facts. After determining what happened, the crisis team must begin to make decisions about disseminating crisis facts. Specifically, the team must decide what will be said, when to deliver this message, and who will make the announcement(s). These decisions need to be made for both staff and students. Finally, the protocol concludes with identification of specific crisis response responsibilities or actions for the school faculty, guidance staff, and administration.

As is found in the Pitcher and Poland (1992) book, Petersen and Straub also devote significant attention to responding to traumatized students and staff. The volume's exploration of crisis counseling provides information on the impact of crisis events and posttraumatic stress disorder. In addition, it provides detailed discussions of specific activities for responding to traumatized youths.

Special concerns for specific crises. Petersen and Straub's suggestions for crisis preparedness acknowledge that certain crisis events present special circumstances that should be anticipated. Special discussion is devoted to suicide, natural disaster, death, and violence. In addition, within the context of responding to student violence, the book also offers security and safety preparedness suggestions.

School Crisis Management (Johnson, 1993)

The focus of *School Crisis Management* is providing staff development that facilitates response to psychological traumatization. In introducing his book, Johnson states that the volume will be "useful in providing directions and resources for training school Crisis Response Teams" (p. 2). He indicates that the book is designed to prepare such teams to provide "appropriate and skillful care" to those "who have been victimized by school crisis" (p. 2). The book includes full-page masters that can be duplicated to produce handouts or overhead transparencies.

Understanding the traumatic stress response. Johnson's approach to crisis preparedness begins by offering guidance on how to facilitate a basic understanding of the traumatic stress response. This includes discussion of: (a) initial and secondary stress reactions (i.e., cognitive, physical, emotional, and behavioral reactions), (b) factors that increase vulnerability to traumatization, (c) posttraumatic stress disorder, and (d) student reactions at various grade levels (i.e., preschool/kindergarten, elementary, junior/senior high).

School crisis intervention. The majority of this preparedness resource is devoted to specific crisis intervention (or psychological first aid) techniques and strategies. Specifically, it promotes staff development in the following areas: (a) provision of crisis intervention at various grade levels (i.e., preschool/kindergarten, elementary, junior/senior high), (b) assessment of individual functioning to offer appropriate response and referral, and (c) group crisis intervention, which is an adaptation of the Mitchell (1983) model.

Crisis response team models. Although relatively little direction is given regarding development of crisis intervention teams, this preparedness resource does suggest two crisis response team models. These models are similar to those described by Petersen and Straub (1992). The first is the centralized team, in which a school district develops one crisis response team that serves the entire district. The second model is the decentralized team, in which a district coordinating committee trains and supervises smaller teams that are located at each school site. The book discusses the strengths and weaknesses of each model.

Special circumstances. Like Petersen and Straub (1992), Johnson's suggestions for crisis preparedness also acknowledge that some crisis events present special circumstances that need to be anticipated. Special discussion is devoted to pre-suicidal behavior, post suicide, murder, sudden loss, family crisis, natural disaster, large-scale disaster, staff trauma, and cumulative stressors.

Care for the caregivers. Acknowledging that crisis intervenors often become secondary crisis victims, this book also suggests that schools be prepared to care for the caregivers. Specifically, its recommendations for staff development include suggestions designed to improve the crisis response team's self-care.

Coping With Crisis (Poland and McCormick, 1999)

This book builds upon the work of Pitcher and Poland (1992) and was greatly influenced by Poland's experience as the former chairperson of the National Association of School

Psychologists' National Emergency Assistance Team (NEAT). As NEAT chairperson, Poland had led national crisis teams following school shootings in Paducah, Kentucky; Jonesboro, Arkansas; Littleton, Colorado; and Santee, California. This book provides a wealth of resources in the areas of school safety, violence prevention, and crisis intervention.

Case studies. One of the unique features offered by Poland and McCormick is thorough case studies. These examples of crisis teamwork relate the efforts of the Poland-led crisis team responses in both Paducah and Jonesboro. For example, the Jonesboro case study relates that the team arrived at Westside Middle School 24 hours after the shooting. The school is described as having been like the epicenter of an earthquake. Poland and McCormick report that the national team helped the school system take control of the overwhelming number of national and international media personnel who were covering the story.

Managing the three waves of a crisis. From the work of Petersen and Straub (1992), Poland and McCormick suggest that the following three waves descend on a school after a crisis: (a) police and medical personnel, (b) media, and (c) parents. Poland and McCormick provide first-hand accounts of how these three waves were managed following school shootings in Paducah and Jonesboro. Major sections of the book are devoted to helping school personnel develop advance plans to manage a crisis.

Community and school partnerships. Poland and McCormick make a compelling case for why school and community must work together in the aftermath of a tragedy. They provide examples of how national and local community mental health providers, clergy, and law enforcement officers can partner with school personnel.

A crisis processing model. As with all of the other books discussed above, Poland and McCormick also discuss how to respond to psychologically traumatized individuals. The specific crisis intervention model described by Poland and McCormick is based upon a program developed by the National Organization of Victims Assistance (Young, 1998). The book offers significant discussion of this model and how it may be used in the school setting. The roles of "facilitator," "scribe," and "caregiver" are outlined from a theoretical perspective and practical suggestions are provided.

The role of parents. Poland and McCormick assert that assisting adults and especially parents is essential to helping students following crisis events. Practical examples of conducting meetings for parents are outlined. They emphasize the typical reactions of students after a tragedy, including (a) fear of the future, (b) academic and behavioral regression, and (c) nightmares and difficulty sleeping. The book provides specific guidelines on how parents can assist children.

Suicide. Another unique feature of the Poland and McCormick book is its significant discussion of suicide intervention. This discussion makes use of information from Poland's first book titled *Suicide Intervention in the Schools* (1989). This discussion makes the point that most youth suicides could be prevented with greater awareness of suicide warning signs and prompt mental health treatment. The authors also outline practical suggestions for postvention in accordance with guidelines from the American Association of Suicidology (1998).

Preparing for Crises in the Schools (Brock, Sandoval, & Lewis, 2000)

Building upon the earlier contributions of Johnson (1993), Petersen and Straub (1992), Pitcher and Poland (1992), and Poland and McCormick (1999), the most recent book to address the topic of crisis preparedness is the second edition of *Preparing for Crises in the Schools*. This book provides what is perhaps the most basic discussion of crisis preparedness. Based on the authors' crisis response experiences and study, this book offers an examination of school crisis response plan initiation and implementation.

Staff development. Staff development is an important part of the Brock et al. recommendations for school crisis preparedness. Specifically, this volume offers recommendations for self-education and includes a training program designed to facilitate the development of crisis intervention skills.

School policy. Recognizing that crisis events, especially major disasters, are relatively rare occurrences, Brock et al. argue that it is essential to institutionalize the school crisis response. Without such institutionalization, the authors suggest that crisis preparedness efforts may not be maintained. The recommended vehicle for institutionalizing crisis preparedness is the development of a school board policy statement. With such a policy, schools do not have a choice regarding whether or not they prepare for crises. Ideally, such a policy mandates at least annual reviews of crisis preparedness.

Team development. Like Johnson (1993), Petersen and Straub (1992), and Pitcher and Poland (1992), Brock et al. also recommend the development of multiple crisis response teams. Specifically, they recommend that each district have its own district-level crisis response team, as well as multiple school-site-level teams. The district-level team has several responsibilities. First, it is available to individual schools to provide direct crisis intervention services following major crises—crises that overwhelm available school-site resources. Second, it is available to consult with school-site crisis teams as they respond more or less independently to less overwhelming crises. Finally, the district-level team helps to coordinate and train local school teams. In the Brock et al. model, school-site-level teams are considered the first line of defense. To the extent that it is possible, this model recommends that schools sites respond independently to their own crisis situations. Obviously, this expectation calls for a significant degree of crisis preparedness at all schools throughout a given school district.

Crisis planning. As was done by Petersen and Straub (1992), Brock et al. also offer a checklist designed to facilitate crisis planning. Primarily, this aspect of crisis preparedness involves the identification of specific individuals (and alternates to serve in their absence) to fill several specific crisis response roles. Most importantly, this model calls for the identification of a crisis response coordinator (usually an administrator) who initiates and oversees all crisis preparedness and response activities. Other team members include a crisis intervention coordinator, a media liaison, a security liaison, a medical liaison, and a team of crisis intervenors. Each of these team members has specific preparedness and intervention responsibilities.

Crisis response. As with Petersen and Straub (1992), Brock et al. also include a protocol for responding to crisis events. This protocol indicates that the first step in responding to a crisis is to determine crisis facts and estimate the impact of the crisis on the school. Next, the crisis team is assembled and a determination is made regarding the need for outside support (i.e., from the district-level team). Once crisis facts have been verified, the next step is for the crisis team to begin to make decisions about what and how information about the crisis will be disseminated to faculty, students, parents, and the community. Next, the protocol directs the team to identify and respond to psychological trauma victims. Finally, the protocol concludes with an acknowledgment of specific logistical details (e.g., establishing a base of operations), the need for debriefings, and memorial considerations.

Evaluation. Brock et al. acknowledge that no two crises are alike. As such, all crises are learning experiences. From this perspective, they recommend that evaluation of each crisis response be made a part of the crisis plan. From such analysis, crisis plans will be strengthened.

Care for the caregivers. As with Johnson's (1993) book, Brock et al. acknowledge that crisis response takes its toll on crisis responders. Thus, this crisis preparedness model also includes discussion of psychological debriefing. The stated goal of such debriefing in this model is to prevent and/or detect burnout among crisis responders and to assist with stress management.

The Need for Research

Research investigating the status and effectiveness of crisis services in general, let alone of the school crisis response in particular, is much needed (U.S. Department of Health and Human Services, 1999). Currently, there is a vast body of anecdotal reports regarding the need for, and effectiveness of, the school crisis response. There is, however, no empirical research investigating these interventions. In the following paragraphs, we offer some basic questions that future research needs to address.

How prepared are we? One area of needed research is examination of the status of crisis preparedness in today's schools. Prior study by Wise, Smead, and Huebner (1987) suggested that although most school psychologists believed that crisis intervention was an important area, they felt inadequately trained for the role of crisis intervenor. Follow-up research to determine the current readiness of educators to fulfill crisis response responsibilities is important. Data from such studies would provide important guidance to both pre- and in-service training programs.

In addition to assessing individual practitioner readiness, future research should also address the question of school system readiness to respond to crisis events. We have found that school districts display great variability in crisis preparedness. Even among districts that purport to have a crisis plan, we have found that many are unprepared. Supporting these observations, Sandoval, London, and Rey (1994) report that school suicide prevention programs are not as viable as is often claimed. Data regarding system-level crisis preparedness would give important guidance to policy-setting institutions (e.g., school boards and legislatures).

What are the most important elements of crisis preparedness? Another area of needed research is an examination of what variables are most important to an effective and efficient school crisis response. One specific question that such research might address is the relative efficacy of school- vs. district-level crisis response teams. For example, is it more effective to have one district-level team or multiple school-level teams? Another research direction is the issue of staff development. For example, are particular staff development training models more effective in providing educators with necessary crisis response skills? Answers to questions such as these would be very helpful to crisis planners as they make choices regarding what elements to include in their crisis preparedness plans.

What are the effects of crisis drills? In efforts to become better prepared to respond to school crises, many crisis response teams have engaged in crisis drills. These drills range from tabletop drills (which involve discussion among team members regarding how they would respond to a crisis situation) to realistic portrayals of crisis events. In some communities these drills have involved simulated school shootings, involving SWAT teams and including simulated mass injuries and fatalities (P. J. Lazarus, personal communication, September 6, 2000). Research in this area should investigate the relative efficacy of the different types of crisis drills. In addition, it is important to address the effects that drills (especially realistic simulations) might have on students. Do simulations engender significant anxiety among participants and observers? If so, do the benefits of such drills outweigh their costs?

What are the effects of crisis response? Perhaps the most basic and important future research questions center upon the actual effects of crisis response. In other words, do the activities that crisis preparedness facilitates actually help a school community cope with crises? Is there potential for crisis response to cause harm? While our experiences and observations suggest that an effective crisis response does help individuals cope with traumatic events, there is still a need for empirical research addressing intervention effects. For example, does an effective school crisis response have an impact on posttraumatic stress disorder rates? Answers to questions such as this one are critical to the success of attempts to institutionalize crisis preparedness.

Crisis Preparedness Recommendations

From the available crisis preparedness literature, and our experiences, we offer the following crisis preparedness recommendations. It is hoped that these guidelines will assist educators in better preparing schools for situational crises.

Develop Crisis Response Teams

A critical first step in the development of an effective and efficient crisis preparedness plan is the creation of a crisis response team (Brock, 2002). Recommendations for completing this task are provided below.

Staff development. The first step in developing a crisis response team is to provide opportunities for participants to obtain necessary background knowledge. Specifically, it is important for the crisis response planner to have an understanding of what the crisis response involves and what situations may require its use. In addition, it is critical to know the defining characteristics of the person in crisis and to understand how to provide crisis intervention. Options for obtaining such knowledge include reviewing the literature,[3] training program participation,[4] and the Internet.[5]

Obtaining administrative support. Having obtained necessary background knowledge, the next step in team development is to solicit administrative support. Experience with crisis response planning suggests that the formation of a planning committee can be a helpful tool in obtaining such support (Brock, 1994, 2000, 2002). Once administrative support is obtained, such a planning committee can be transformed into a crisis response team.

Any planning committee should be representative of the district or the school(s) within which the planning is to take place. Its efforts should focus on obtaining and disseminating the knowledge needed to undertake crisis response planning, and then to develop crisis preparedness procedures.

It needs to be acknowledged that some school administrations may not be receptive to crisis preparedness efforts. Our recommendation in such a situation is to not let resistance interfere with preparedness efforts (Brock, 2000, 2002). Experience suggests that there will come a time in the life of every school when it will be receptive to crisis preparedness. Unfortunately, this is often immediately after a situational crisis.

Defining crisis response roles. Another critical crisis response team development activity is to define specific crisis response roles. Examples of specific team roles include the following: Crisis Response Coordinator, Crisis Intervention Coordinator, Emergency Medical and Health Coordinator, Security and Safety Coordinator, and Debriefing and Evaluation Facilitator (Brock, 2002; Pitcher & Poland, 1992). In addition, response teams should also have several individuals designated to fill the role of

BEST COPY AVAILABLE

crisis intervenor. Further discussion of the planning and response responsibilities of each of these roles is offered later in this chapter.

Developing "levels" of crisis response. Along with the identification of individual crisis response roles and responsibilities, crisis response team development activities should also identify institutional roles and responsibilities. We conceptualize it as involving the delineation of crisis response "levels" (Brock, 1998, 2002; Brock et al., 2000; Pitcher & Poland, 1992). Specifically, we recommend crisis preparedness include the development of multiple hierarchical teams.

The primary level of crisis response team should be the school-site-level team. We have found that well-prepared school teams are typically able to independently respond to most crises. The importance of these teams is highlighted by the fact that it can be reassuring for crisis victims to see familiar school staff members responding to a crisis. Conversely, it can increase threat perceptions if the crisis response team is composed of individuals not typically a part of the school. At the same time, however, it must be acknowledged that situational crises have the potential to affect an entire school and consequently overwhelm available site-level resources. It is this possibility that makes multiple hierarchical teams essential. Thus, we recommend that school district-level and/or regional-level crisis response teams also be developed. All teams, regardless of level, should have a similar structure (i.e., have individuals designated to fill the roles suggested above).

Plan for the Crisis Response

Planning for the crisis response should be initiated and supervised by a school administrator filling the role of Crisis Response Coordinator. In addition, this individual should ensure that crisis response plans are not allowed to sit on a shelf collecting dust. This individual should, at least annually, engage in the following preparedness activities.

Prepare for crisis intervention. A school mental health professional, filling the role of Crisis Intervention Coordinator, should initiate planning for the provision of crisis intervention services to psychological trauma victims. Specifically, this individual ensures that psychological first aid (or crisis intervention) resources are available. In addition, he or she develops procedures for identifying and referring psychological trauma victims, and knows what community resources are available to assist during times of crisis (e.g., community mental health centers).

Prepare for working with the media. An administrator or public relations specialist, filling the role of Media Management Coordinator, should initiate planning for working with the media during times of crisis. Specifically, this individual establishes communication links with local media personnel and establishes procedures and/or rules for working with the media during crises. In addition, he or she should also develop prepared statements (or templates) that can be quickly adapted to help with the dissemination of crisis information.

Prepare for security following a crisis. A school police officer or administrator, filling the role of Security and Safety Coordinator, should initiate planning for school safety and security. Specifically, this individual ensures that security and safety plans are made (e.g., parent/student reunification procedures, staff identification procedures, evacuation procedures, danger/evacuation signals, bomb threat procedures, and traffic management procedures). In addition, he or she should establish communication links with local law enforcement.

Prepare for medical issues. A school health professional, filling the role of Emergency Medical and Health Coordinator, should initiate planning for the provision of medical first aid to trauma victims. Specifically, this individual ensures that medical first aid resources are available. In addition, he or she should establish communication links with local emergency response personnel (e.g., community health centers and paramedics).

Prepare for crisis team debriefing. Planning for the provision of critical incident stress debriefing should be initiated by a school mental health professional filling the role of Debriefing and Evaluation Facilitator. Specifically, this individual ensures that debriefing resources can be made available to crisis response team personnel following conclusion of a crisis response.

Conduct drills or readiness checks. The final recommended preparedness activity is to conduct drills or readiness checks. Tabletop drills, which involve crisis response team discussion of how members would respond to various crisis situations, are recommended. The Debriefing and Evaluation Facilitator is responsible for conducting this activity.

Crisis Response Procedural Guidelines

The final, and arguably the most important, crisis preparedness activity is the development of crisis response procedural guidelines. These guidelines specify the actions to be undertaken following a situational crisis event. As with crisis planning activities, crisis response should be initiated and supervised by a school administrator filling the role of Crisis Response Coordinator. Recommended crisis response procedures include the following actions.

Assess the crisis. The first step in a crisis response is to gather and assess crisis facts. It is recommended that the Crisis Response Coordinator undertake this task. From the available information, a determination regarding whether a crisis exists is made, the level of response is estimated (i.e., school-site- or district-level), the crisis team is assembled, and the response is initiated.

Address medical needs. Facilitated by the Emergency Medical and Health Coordinator, the crisis response team should immediately offer medical first aid to those who are physically injured. Such intervention would typically continue until professional emergency medical response personnel arrive on the scene. As appropriate, the Emergency Medical and Health Coordinator also helps to ensure that noninjured students are shielded from scenes of blood and carnage. Once the emergency response has concluded, this Coordinator maintains communication with health care professionals to keep the crisis response team informed regarding the status of the injured.

Consider security and safety needs. Facilitated by the Security and Safety Coordinator, the crisis response team should also begin to implement the general security procedures previously developed. For example, procedures designed to reunite students with their parents may need to be implemented. In addition, once the emergency response has concluded, the Security and Safety Coordinator maintains communication with law enforcement. From such communication, this Coordinator is able to keep the crisis response team informed regarding the status of any investigation.

Disseminate crisis information. Facilitated by the Media Management Coordinator, the next step is for the crisis response team to make decisions regarding what and how crisis information will be shared with staff, students, and the community. This response procedure also involves the implementation of previously developed procedures and/or rules for working with the media during crises.

Assess psychological trauma and provide crisis intervention services. Facilitated by the Crisis Intervention Coordinator, the crisis response team should as soon as possible begin to identify psychological trauma victims. Teacher, parent, and self-referral procedures also need to be made available. As victims are identified, they need to be offered crisis intervention services. The cadre of crisis intervenors, developed as a part of crisis preparedness activities, should provide these services. The Crisis Intervention Coordinator should supervise this response.

Debrief and evaluate the crisis response. Finally, as the intervention concludes, the crisis response team should be debriefed and the response itself evaluated. The Debriefing and Evaluation Facilitator initiates these activities. Typically, this individual will not have been a part of the crisis response.

Concluding Comments

According to Ronald Stephens, Executive Director of the National School Safety Center, there are two types of schools: those that have and those that will experience a significant crisis event. Although prevention efforts are essential, it also is important to acknowledge that not all crisis events can be stopped. Thus, it is critical for schools to be prepared to respond to crises. We hope that the information provided in this chapter will assist schools with such preparedness efforts.

References

Adams, C. M. (1996). Adolescent suicide: One school's response. *Journal of Secondary Gifted Education, 7*, 410-417.

American Association of Suicidology. (1998). *Postvention guidelines for the schools: Suggestions for dealing with the aftermath of suicide in the schools* (2nd ed.). Washington, DC: Author.

Brock, S. E. (1994, June). Crisis preparedness: Strategies for the development of a crisis intervention policy. NASP *Communiqué, 22*(8), 24-25.

Brock, S. E. (1998, November). School crisis intervention mutual aid: A county-level response plan. NASP *Communiqué, 27*(3), 4-5.

Brock, S. E. (2000). Development of a school district crisis intervention policy. *The California School Psychologist, 5*, 53-64.

Brock, S. E. (2002). Preparing for the school crisis response. In J. Sandoval (Ed.), *Handbook of crisis counseling, intervention and prevention in the schools* (2nd ed., pp. 25-38). Hillsdale, NJ: Erlbaum.

Brock, S. E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools: A manual for building school crisis response teams*. Brandon, VT: Clinical Psychology Publishing Company.

Brock, S. E., Sandoval, J., & Lewis, S. (2000). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Cornell, D. G., & Sheras, P. L. (1998). Common errors in school crisis response: Learning from our mistakes. *Psychology in the Schools, 35*, 297-307.

Fairchild, T. N. (Ed.). (1997). *Crisis intervention strategies for school-based helpers* (2nd ed.). Springfield, IL: Charles C. Thomas.

Johnson, K. (1993). *School crisis management: A hands-on guide to training crisis response teams*. Alameda, CA: Hunter House.

Mathers, K. (1996). Never again would we be the same: The Oklahoma City bombing. *NASSP Bulletin, 80*, 38-43.

Mitchell, J. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Services, 8*, 36-39.

Mitchell, J. T., & Everly, G. S. (1996). *Critical incident stress management: The basic course workbook*. Ellicott City, MD: International Critical Incident Stress Foundation.

Nye, K. P. (1997). He's got a gun! *American School Board Journal, 18*, 43-45.

Petersen, S., & Straub, R. L. (1992). *School crisis survival guide: Management techniques and materials for counselors and administrators*. West Nyack, NY: Center for Applied Research in Education.

Pitcher, G., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.

Poland, S. (1989). *Suicide intervention in the schools*. New York: Guilford Press.

Poland, S., & McCormick, J. (1999). *Coping with crisis: Lessons learned. A complete and comprehensive guide to school crisis intervention*. Longmont, CO: Sopris West.

Ramsay, R. F., Tanney, B. L., Tierney, R. J., & Lang, W. A. (1996). *Suicide intervention workshop* (6th ed.). Calgary, AB: LivingWorks Education.

Ruof, S. & Harris. J. (1988, May). Suicide contagion: Guilt and modeling. NASP *Communiqué, 16*(7), 8.

Sandoval, J. (Ed.). (1988). *Crisis counseling, intervention, and prevention in the schools*. Hillsdale, NJ: Erlbaum.

Sandoval, J. (Ed.). (2002). *Handbook of crisis counseling, intervention, and prevention in the schools*. (2nd ed.). Hillsdale, NJ: Erlbaum.

Sandoval, J., London, M. D., & Rey, T. (1994). Status of suicide prevention in California schools. *Death Studies, 18*, 595-608.

Slaikeu, K. (1984). *Crisis intervention: A handbook for practice and research*. Newton, MA: Allyn & Bacon.

Slaikeu, K. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Newton, MA: Allyn and Bacon.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author.

Wise, P. S., Smead, V. S., & Huebner, E. S. (1987). Crisis intervention: Involvement and training needs of school psychology personnel. *Journal of School Psychology, 25*, 185-187.

Young, M. A. (1998). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

Endnotes

[1] For additional discussion of "situational crises," the reader is referred to Chapter 1, Crisis Theory: A Foundation for the Comprehensive Crisis Prevention and Intervention Team.

[2] The reader is referred to Chapter 1, Table 3, on page 12, for a list of psychological problems commonly associated with psychological traumatization.

[3] In addition to the resources discussed above, recent articles by Adams (1996), Cornell and Sheras (1998), Mathers (1996), and Nye (1997), and books by Fairchild (1997) and Sandoval (1988, 2002) will be helpful to the crisis response planner.

[4] Examples of specific programs include Basic and Advanced Critical Incident Stress Management (Mitchell & Everly, 1996), Suicide Intervention Workshop (Ramsay, Tanney, Tierney & Lang, 1996), and National Community Crisis Response Team Regional Training Institute (Young, 1998).

[5] The reader is referred to Brock (2000) and Brock et al. (2001) for further discussion of Internet websites that may be of assistance to the school crisis response planner.

Section

3

Secondary Prevention: The Immediate Response to Crisis Events

BEST COPY AVAILABLE

Despite the best of prevention efforts, it needs to be acknowledged that some crisis events cannot be prevented. Thus, the next three sections of this book are devoted to actions undertaken following the occurrence of crisis events. In Section III, chapter authors describe what might be considered relatively generic crisis response and intervention principles. First, they review cultural considerations (Chapter 15 by Jonathan Sandoval and Sharon Lewis) and developmental issues (Chapter 16 by Bill Pfohl, Shane Jimerson, and Philip Lazarus) important to the school crisis response. Clearly, one size does not fit all when it comes to the crisis response, and crisis interventions must be tailored to the unique needs of different age and cultural groups. It is hoped that these chapters will help sensitize the reader to these special needs.

Next, we provide an overview of the crisis response team (Chapter 17 by Marlene Young) and a discussion of how to determine the appropriate level of crisis response (Chapter 18 by Stephen Brock). We hope that the reader will gain from these chapters a better understanding of what the crisis intervention response may include and how the specific characteristics of a given crisis event will determine the amount of crisis intervention team assistance required.

Finally, Section III concludes with three chapters designed to offer guidance regarding the identification and immediate treatment of psychological trauma victims. The chapter on identifying trauma victims (Chapter 19 by Stephen Brock) will help the reader to make crisis intervention treatment priorities (i.e., psychological triage). The chapters on immediate treatment (e.g., crisis intervention or psychological first aid) review both group (Chapter 20 by Stephen Brock) and individual (Chapter 21 by Kathleen Nader and Paulette Muni) approaches. These chapters will promote more informed decisions regarding the immediate treatment of psychological trauma victims.

15

Cultural Considerations in Crisis Intervention

危機

Jonathan Sandoval, Ph.D.
University of California, Davis

Sharon Lewis, M.A.
Lodi Unified School District (Lodi, CA)

Our schools, more rapidly than any other institution, are going through tremendous change. The children and the families schools serve are becoming increasingly diverse. Since 1985, the number of children entering school without full English proficiency has grown by about 70%. One school-age child in seven speaks a language other than English at home (Garcia, 1995). Ethnic minority students comprise 70 to 96% of the students in 15 of the nation's largest school districts (Kellogg, 1988). Much of this diversity is the result of immigration from Mexico and Central America and from economically depressed or war-torn areas of the world. Extra stressors, including poverty, discrimination, and need for assimilation, are present in the lives of immigrant and many other culturally diverse groups. (See Chapter 29, Traumatized Refugee Children, for additional information on this topic.) Many migrating families have already experienced crisis events in their home country, such as torture, rape, and loss of home and family. As a result, these children and their families may be particularly vulnerable when school-related crises occur. Many culturally diverse groups also are at the bottom of the economic pyramid in this country. Poverty will be a factor in how they respond and are able to cope when a crisis occurs (Doll & Lyon, 1998). Lack of family resources (e.g., not having the funds to properly bury a deceased family member) exacerbates trauma (Lewis, 1970). The effects of cumulative stress or unresolved issues related to grief and/or previous trauma make these individuals more at risk for post-traumatic stress disorder.

Everyone has a culture. In fact, individuals function in a number of cultures, starting with the family and including a national identity, a religious identity, an ethnic identity, or a professional identity. The concept of culture is very complex (cf. Frisby, 1998). One simple definition of culture is the shared language, ideas, beliefs, values, and behavioral norms of a group of individuals with a group identity. Culture regulates how individuals interact with one another and provides a structure for organization to occur. Culture is not a static phenomenon; it is constantly evolving. Children come from a culture, but are early on exposed to the school culture, which is often closely related to the dominant culture. Children in a family are usually the first to acculturate to the dominant culture, which causes additional problems and stressors for the family.

The relationship of culture to crisis is manifold. It may help to determine *what incidents are perceived as crises*, and it will impact *how an individual deals with crises*. Moreover, it may dictate *appropriate ways of helping an individual during crisis*. This chapter will cover these three topics. It also will consider the general construct of "culture," and the competencies of a multicultural counselor. Finally, we will offer recommendations for crisis intervenor training and a model of culturally responsive crisis intervention.

Culture and the Counselor

This chapter emphasizes the importance of considering culture in responding to crisis. But it must also be remembered that each individual also has a personality, and that personality may be consistent or inconsistent with the culture from which the person comes. As a result, one cannot presume that an individual shares all of the ideas, beliefs, values, and norms of the group with which he or she identifies. Individual and regional variation always exists within a particular culture. In addition, an individual may identify with more than one group, such as someone who considers herself gay, African American, and Buddhist. When approaching someone with multiple identities, it may be difficult to predict which values and behaviors will be manifest. The safest stance is to be aware of the shared worldview of different cultures so they may be recognized and used, but to proceed with caution to avoid stereotyping and making unwarranted assumptions. Both crisis intervenors and youths in crisis are individuals first and group members second.

Cultural Variation

The dominant culture in the United States and Canada is shared by many crisis intervenors. Crisis intervenors are typically middle class, well educated, English monolingual, and assimilated into the western European culture. The victim may share that culture or may come from an entirely different tradition and not be a native English speaker. If there is a disjuncture between the culture of the crisis intervenor and that of the student and family, it must be addressed. It can be addressed by increasing training for the crisis intervenor or making an appropriate referral. We will return to these points later. Ideally, a crisis response team would be comprised of all the cultures represented in the school. Unfortunately, it is not always possible to achieve this goal. Crises occur at unpredictable times, and the diversity of many schools is so great it would be impossible to have trained personnel available for every student or family member at a moment's notice.

Many scholars argue that the dominant culture of the United States is derived from the white Anglo-Saxon Protestant tradition (Spring, 2000). The core values include mutual respect, individual rights, tolerance of differences, the rule of law, democracy, and individual achievement. These values are expressed in connection with schooling, work, family, social organization, property, and the environment. The core values of other cultures may or may not conflict with these values.

Some differences between non-Western and the dominant Western culture may include the following:

- Group cooperation vs. individual competition
- Achievement as it reflects group vs. achievement for the individual
- Harmony with nature vs. mastery and control of nature
- Time is relative vs. adherence to rigid time schedule
- Accept affective expression vs. limit affective expression
- Extended family, clan vs. nuclear family
- Holistic thinking vs. dualistic thinking
- Religion permeates culture vs. religion distinct from other parts of culture
- Accept worldview of others vs. believe own worldview is superior
- Socially oriented vs. task oriented

The dominant culture in the United States, for example, values independence and individuality. It favors self-expression and democratic family relationships. Family ties are loose, and parents are primarily responsible for their children. There is a belief that individuals can change and control events, that nature can be dominated, and that it is possible to plan for the future. Competition and achievement are valued, as is punctuality.

In contrast, the Latino culture, for example, may be characterized as believing events are controlled by fate (God) rather than humans. Interpersonal relationships are highly valued, as is the extended family. Many relations are hierarchical, rather than democratic. Time is flexible and extendable. Dignity and honor are highly respected, as is group cooperation.

Given that many crisis intervenors are products of the dominant culture, a major question is: "How can counselors with this worldview learn to work with members of a different culture?" The answer is not simple. A first step is to learn about one's own culture and to recognize legitimate differences in the worldview of others. Counselors are typically taught to suspend their value judgments in working with others, but are not often prepared to work with others with truly different concepts of how the world operates. What it takes to do this work has been the object of some thought.

Competencies of the Multicultural Counselor

Sue and his colleagues have outlined the competencies needed for effective multicultural counseling (Sue et al., 1998). They list three general dimensions: (a) counselor awareness of own assumptions, values, and biases; (b) understanding the worldview of the culturally different client; and (c) developing appropriate intervention strategies and techniques. Under each of these dimensions are listed a set of attitudes and beliefs, knowledge, and skills. Some of the skills included under the third dimension are the ability to use a variety of verbal and nonverbal helping responses and willingness to consult as appropriate with traditional healers or spiritual leaders and practitioners in the treatment of culturally different clients. Sue et al. state: "Becoming multiculturally competent means the ability to free one's personal and professional development from the unquestioned socialization of our society and profession" (Sue et al., 1998, p. 37). In addition,

> Multiculturally competent counselors also consider factors such as the impact of the sociopolitical system on people of color in the United States, have knowledge and information about particular cultural groups, and are able to generate a wide range of appropriate verbal/nonverbal responses to client needs. (Pope-Davis & Dings, 1995, p. 288)

The process of gaining multicultural counseling competencies involves study, prolonged exposure to other cultures, self-examination, and supervision. The first step is often making counselors aware that they do have a set of culturally determined attitudes and beliefs. To aid in determining whether these competencies have been met, a number of assessment devices have been developed and are reviewed by Pope-Davis and Dings (1995).

Culture and the Perception of Crisis

Many events that frequently stimulate a crisis reaction in the dominant culture, such as a death, suicide, or natural disaster, may or may not have a similar effect on members of other cultures. By the same token, an event that would scarcely be noted in the dominant culture, such as eating a particular taboo food by accident, could stimulate a crisis reaction in another culture.

Young (1998) offers an example of a young adolescent on welfare, living in public housing, who had been raped. Rather than being traumatized and entering into a crisis state as a result of the sexual assault, the young woman expressed disappointment that the rape had not resulted in a pregnancy, which would have led to an opportunity to move out on her own. Although this is an extreme example, it should prompt the crisis intervenor to be cautious in assuming that a given event will be perceived as a crisis.

Cultural lenses also will determine how a community views a crisis response. For example, the traditional school celebration of St. Patrick's Day (wearing green and making shamrocks) shortly after a January school shooting, caused misperceptions by Southeast Asian students and families. These families thought the school was glorifying the perpetrator, whose first name happened to be Patrick. This misperception triggered distress and required a careful explanation regarding the origins of this holiday.

Cultural Factors and the Reaction to Traumatic Events

Terr (1991) defined childhood crisis reaction or trauma as "the result of one sudden, external blow or series of blows rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations" (p. 10). Typical crisis reactions include confusion, disorientation, and disturbed problem-solving abilities. The usual sequelae of childhood trauma, according to Terr, are strongly visualized or otherwise repeatedly perceived memories, repetitive behaviors, trauma-specific fears, and a sense of severely limited future. These reactions are found regardless of the source of the traumatic event or the age of the child. Each of these behavioral consequences of a crisis could interrupt the child's ability to function cognitively and socially in the classroom. The consequences will manifest themselves in written work, disruptive or negative behavior, and the inability to play by oneself or with others. The most dramatic psychosocial outcome of childhood trauma is the development of multiple personality disorders (Terr, 1991). Aside from these general outcomes, how these sequelae manifest themselves may have a strong cultural component. For example, fears and nightmares may have a focus on spirits and ghosts. Confusion and poor coping may appear to be a lack of understanding of English, rather than a crisis reaction. Confusion and disorientation may be attributed to cultural differences.

Sometimes a reaction to a traumatic event may be culturally appropriate, but will seem to Western eyes to be a breakdown of ordinary coping. Extreme outward expression of grief by wailing and crying followed by self-mutilation and threats of suicide following the death of a loved one may be normal coping behavior expected of a survivor in a particular Middle Eastern culture. A culturally knowledgeable informant will be very useful in indicating normal reactions to various traumatic events for a particular culture. Klingman (1986) offers the example of a medical staff that considered sedating a grieving person although the perceived extreme response was actually normal for a person from that culture.

In Hispanic culture, an adult may react to a crisis event by deciding not to tell the children of the crisis in order to protect them (M. Bellatin, March 9, 1995, personal communication). Family secrets may be kept if nobody asks or talks about such issues as illness, death, sexual abuse, or suicide. Crisis intervenors should be aware that youths coming from a cultural background with this belief might not have the opportunity to tell their crisis story at home. In Arabic culture, adults may resist discussing illness or death because of the belief that such discussion can lead to misfortune or make a bad situation even worse (Wilson, 1996). In Asian culture, denial and guilt may be part of cultural values in which human suffering is seen as part of the natural order (Li & Liu, 1993). Value may be placed on maintaining dignity and emotional strength. Thus, emotions may be suppressed to maintain dignity.

Additionally, knowledge of cultural reactions to trauma may inform the crisis intervenor of strengths to tap for crisis intervention. For example, urban black families may have multiple resources available to crisis victims because the extended family may reach deeply into the community (Stack, 1974).

It is also important in planning crisis interventions to ensure that response efforts are provided equitably to all groups. Since prejudice is an unfortunate occurrence in every society, crisis intervenors should be cognizant of the possibility that some may perceive that too much is being done for one group and not enough for another, even if not true. The principles of consistency and fairness need to be applied to crisis response to avoid perceptions of prejudicial treatment.

Cultural Factors and the Response to Traumatic Events

Culture influences a number of areas of everyday life. It influences how we communicate with others, how we express our spirituality, what we accept as our basic values, and even what we eat and what music we enjoy. Several of these dimensions of culture need to be taken into account during crisis intervention.

Language and Verbal Communication

One of the most important manifestations of culture is language. Many important cultural concepts cannot be satisfactorily translated from one language to another, because the meaning is so bound up in cultural values and worldview. If possible, crisis intervenors should speak the same language as their client. An important skill of intervenors is taking

> ... responsibility for interacting in the language requested by the client; this may mean appropriate referral to outside resources. A serious problem arises when the linguistic skills of the counselor do not match the language of the student and family. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor. (Sue et al., 1998, p. 41)

We discuss the use of interpreters in a following section. Whether or not the helper speaks the same language as the student, there are some important socio-linguistic considerations to keep in mind during communication with individuals in crisis.

Socio-linguistic issues. In order not to violate important cultural conventions, it is usually safe to observe good diplomacy. When approaching individuals, they should be greeted appropriately (e.g., "Hello") and the helper should introduce him or herself. Politeness is paramount; the helper should ask permission to speak and to do things for the individual in crisis. Saying "please" and "thank you" is important, as is acknowledging limitations and weaknesses springing from a lack of cultural or linguistic knowledge, and apologizing quickly when an error or gaffe has been committed. Often it will be appropriate to apologize in advance when the helper is uncertain about discussing a sensitive area. Special care should be taken in asking questions. In many cultures asking direct questions is considered impolite. Asking indirect questions (Benjamin, 1981) may yield a better response.

Communication styles. Styles of communication can range from the assertive and voluble to the quiet and indirect. Arabic families, for example, have an assertive style (Wilson, 1996). Often, shouting is used for effect. An initial "no" may mean "yes" unless the no is repeated several times. To be persuasive, it is appropriate to show emotion, repeat points, and pound the table. It is usual to talk around the subject before coming to the point.

In contrast, in Asian cultures there is a subtle use of language and emotions (Li & Liu, 1993). Harmony is valued, and confrontation and argument are avoided. A third person may act as a mediator to facilitate communication between persons in conflict. Emotions are seldom expressed. In contrast to the dominant culture, which values directness, Asians also may prefer to come to the point of a conversation in a roundabout manner.

Working with interpreters. Clearly, it is best for crisis intervention with non-English speakers to be conducted by a crisis intervenor who has demonstrated proficiency in the student's first language. The availability of trained speakers of some languages, such as Spanish, may be sufficient but, given the large number of languages spoken in the United States, it is not possible to match every non-English speaker to a helper proficient in the native tongue. Instead, crisis intervenors need to be prepared to work with interpreters. Such training may be obtained from workshops or by consultation with an experienced psychologist or counselor.

Before working with an interpreter, the first task of the crisis intervenor is to learn about the dynamics of the interpretation process. Some of these dynamics include how to establish rapport with participants, how to anticipate the loss of information inherent in the interpretation procedure, how to use the authority position of the professional, how to use appropriate nonverbal communication, what methods and techniques of interpretation are available, how to obtain accurate translations, and how to discourage personal evaluations by the translator (Figueroa, Sandoval, & Merino, 1984). Crisis intervenors must learn to avoid the common errors of untrained interpreters: omissions, additions, condensations, substitutions, and role exchanges (Vasquez & Janvier, 1991).

The second task is to identify a potential translator (Sandoval & Duran, 1998). In the school setting, teacher aides or noncertificated staff members such as community liaisons may be available. Parents and community members may also serve. Parents, however, should not be used as interpreters with their own children. The best-educated native speaker is often the best candidate to serve as an interpreter, since that person will be able to learn quickly what is needed. However, a well-educated person may have class and dialect differences from the child. In addition to the linguistic competence of the potential interpreter, the individual's personality must be taken into account. Ideally, the interpreter should be someone able to establish rapport with the individual being counseled. McIvor (1994) argues,

> … although helpful, it is not essential that they (interpreters) have knowledge of mental health issues, but it is essential that they have a particular knowledge of the political and cultural background from which the survivor comes. It is often ignored that the interpreter should be socially, ethnically and politically acceptable to the survivor. (p. 268)

A final point in selection is the dialect(s) spoken by the potential interpreter. Newcomers to the United States may speak dialects that others may have difficulty comprehending. For example, the working-class French Creole spoken by the child of a Haitian immigrant may be difficult for a Parisian French speaker to understand. Checking to verify the dialectal match between the student and the interpreter is very important.

The third task is to prepare the interpreter. If translators are inexperienced, it is necessary to educate them in the techniques of translating in a crisis context. Interpreters must learn ethical concepts, particularly the importance of keeping information confidential. They must know how *not* to elaborate on responses or questions inappropriately, how to deal with physical gestures and other kinesthetic information, and how to establish and maintain rapport. The crisis intervenor should go over any unusual terminology that might arise and should verify sensitivity to dialect variants and cultural differences. The intervenor will be using the interpreter as a proxy and should feel confident that good professional practice will be followed. If there is time, interpreters also should be schooled in the elements of psychological first aid.

The fourth task is to hold a pre-intervention conference with the interpreter to carry out detailed planning for the intervention. The purpose of the session and any background information should be discussed. Assuming the interpreter is familiar with the culture of the child, he or she can review for the intervenor the typical behaviors and attitudes of the child's culture in stressful situations. The interpreter is a cultural bridge between the intervenor and the student and family.

The fifth task is conducting the crisis intervention. The session should be a team effort to elicit the best outcome for the participants. The crisis intervenor should direct the process and monitor the situation for signs of distress or failure of the process. It may be necessary to consult with the interpreter about the process, but avoid long discussions in English in front of the student.

The final task is a post-session conference with the interpreter to evaluate the process. It may be useful to audio- or videotape the session if the parent grants permission. The translator's impressions of the child or adolescent should be noted. After the counseling session, the interpreter will also be of assistance in following up on referral, or communicating with parents or community members who may help with providing needed support. The interpreter may also play a key role in facilitating the return to school of absent students, including those injured.

It is important to remember that individuals who serve as interpreters will be subject to being traumatized themselves, by recounting and reliving the crisis experience. They may identify with the victim and may be forced to recall and relive similar crises in their own lives. The crisis intervenor will wish to take time to debrief the interpreter carefully following the crisis intervention (Brock, Sandoval & Lewis, 1996). Some form of counseling might be appropriate for the interpreter, such as Critical Incident Stress Debriefing (Mitchell, 1988).

Nonverbal Communication

Attention to nonverbal communication also is important during crisis intervention. A number of dimensions, including eye contact and proximity, can be very different between members of different cultures (Hall, 1959). Hall has pointed out a number of domains of nonverbal communication. Because these behaviors are subtle, intervenors may easily miss them.

Eye contact. In our dominant culture, we traditionally make direct eye contact and then our gaze drifts during conversation. In contrast, in Middle Eastern culture, sustained eye contact is the norm whereas in Asian and Native American groups, direct eye contact is avoided in an effort to show respect.

Proximity. In conversation, dominant culture members prefer some space, up to 5 feet between discussants. In contrast, both Hispanic and Arabic conversationalists will gravitate to a shorter space, perhaps 2 feet, between discussants. Such close proximity would seem unnatural to a member of the dominant culture.

Gestures and physical contact. Some cultures use more gestures while speaking than do others. The eastern Mediterranean cultures are particularly known for gesticulating as they speak. Smiling, giggling, and laughing may be particularly misleading. In Asian culture, these all may denote suppression of emotion rather than insensitivity. The same smile in a traditional Vietnamese person may mean happiness or sorrow, agreement or disagreement, embarrassment or confidence, comprehension or confusion.

Westerners view touching as appropriate following a traumatic event as it assists a person in crisis to feel comforted and less alone. Children often find it comforting to be held following a crisis. Physical contact such as shaking hands or embracing between a helper and a child or adolescent, however, may be inappropriate in some cultures (e.g., Hmong) although appropriate in others (e.g., Hispanic). Cultures often have taboos regarding the appropriateness of touching. In Western culture, it may be perceived as inappropriate for males to touch. Within Asian cultures (Liu & Li, 1994) touching is acceptable between members of the same gender, although shaking hands is more acceptable than hugging. Among the Hmong it is inappropriate (especially for males) to touch a child on the head.

Religion

Religious tradition and the spirituality that goes with it is of enormous help during a crisis. Religious rituals often are associated with the crises people encounter, particularly death. Knowledge of the grieving process and traditions of various cultures is indispensable to crisis intervenors.

Religious worldviews that emphasize mystery about life and the role of fate or luck permit believers to make sense of traumatic events and find meaning. We were impressed, for example, with the helpfulness of an exorcism by a Buddhist monk following a schoolyard shooting. This ritual enabled the school's Cambodian children to return to class relatively peacefully a week following the incident. Facilitating other culturally relevant healing rituals is helpful following a crisis incident. Relaxation of the typically strict separation between church and state may facilitate a speedier and more positive crisis resolution.

On the other hand, religious injunctions and traditions can also precipitate a crisis when an event takes on added dimensions because of strong taboos. A suicide or a sexual assault, which is a clear crisis in almost any culture, may have even more serious consequences in religions in which these crises bring extra shame to a family or cause children to be unmarriageable.

Holidays. In most religions some days, weeks, and even months have a special significance. In Western culture we are all familiar with Christmas, Lent, and Easter, not to mention the semi-secular feast day of Thanksgiving. We also are aware of Yom Kippur, Ramadan, and the Day of the Dead, but we may not appreciate their significance for both coping with crisis events and for intervening in a crisis. In scheduling events for crisis intervention or prevention, we must be aware of the cultural calendar families are following and avoid conflict. We also must be aware of appropriate holidays where the focus may be on coping with a crisis and support the use of this tool. For example, for families of Mexican heritage, the Day of the Dead (following the Western holiday Halloween) is a time to remember the departed, and come to view death as not just a normal part of life, but also as a blessing.

Working with shamans. According to Lee and Armstrong (1995), all cultural groups have traditional attitudes about defining behavior as abnormal when it is outside the culturally defined boundary of optimal psychological functioning. In many cultures when individuals enter a crisis state, they turn to individuals who are acknowledged within their communities as possessing special insight and helping skills. The anthropological term shaman is used to describe people called medicine man or woman, witch, witch doctor, sorcerer, or traditional healer. Within the shamanic tradition, there is an emphasis on a holistic approach, nonordinary reality, and an emphasis on the psychospiritual realm of personality (Lee & Armstrong, 1995). Although many of the shaman's practices and beliefs may be considered primitive and unsophisticated to Western eyes, these traditional methods have given comfort to crisis victims for millennia.

If a student is from shamanic culture, it may be useful to locate a traditional healer or shaman from the community and consult with them as appropriate. Richardson (1991) recommends that, after exploring a student's worldview, determining that the belief system includes traditional beliefs, and determining that the student or the family could benefit from the services of a traditional healer, it will be appropriate to elicit the aid of the shaman. Folk healers may be difficult to identify, since they are not known outside their community, but the family or others in the community can help to locate them. The intervenor must remember to respect the skill of the healer even if he or she does not accept the system of healing. Richardson states,

> … a counselor must be willing to form a working partnership with a traditional healer, if necessary. As with all consultative relationships, the goal is to help the student. An integral part of such a relationship should be the establishment of treatment boundaries that respect both Western psychological traditions and the universal shamanic tradition. (Lee & Armstrong, 1995, p. 452)

The Western crisis intervenor should be available to participate, if invited, in ceremonial activities or practices that will help the student cope. In preparing for crises, having a referral system in place that includes traditional healers may be important.

Other Cultural Factors

Food. During times of crisis, food is often an important source of solace. Although when under stress, a person's appetite tends to diminish, the need for nourishment remains. In many cultures, friends and neighbors provide food to those who are grieving following a death. Since some foods have special meaning as "comfort food," it may be helpful to provide ethnically appropriate food to victims. Sharing a simple drink (nonalcoholic) is often a way to start a relationship. Offering tea, for example, to a Japanese client (Alexander & Sussman, 1995) is a simple gesture that can help two people from different cultures form a therapeutic alliance.

Music. Music has been proven to be a beneficial tool in relaxation training and in other therapeutic settings (Alexander & Sussman, 1995). Culturally appropriate music may be very helpful in waiting rooms or other locations to facilitate coping during crisis situations. The use of music has not been explicitly evaluated in crisis contexts, but it should be examined. We predict it would have a welcoming effect on students wary of a helper from a different culture.

Dress. Many cultures have expectations about what is considered appropriate or modest dress. In much of the world, men are expected to wear suits and women to wear dresses. Modesty may involve covering the head or other parts of the body. Following a crisis, victims may not have access to traditional dress, and this may cause extra distress. Blankets should always be available to cover the body. Crisis intervenors should attempt to dress conservatively and professionally, because such an appearance will help inspire confidence as well as show respect. For example, in one instance we witnessed a professional dressed in blue jeans lose credibility instantly during a meeting with Southeast Asian crisis victims.

Gifts. Small presents or gifts are used in many cultures to offer thanks or to commemorate a loss or anniversary. Familiar Western examples are flowers at a funeral or a note of sympathy. These concrete, nonverbal expressions are important, and a gift of thanks following a crisis intervention should be accepted graciously. Similarly, culturally appropriate gestures of memorialization from individuals, or on behalf of the school, will be helpful to a grieving family.

Social status. Social status refers to a person's position in a social order based on such factors as gender, age, economic position, educational accomplishment, and so on. Each culture may give status to particular individuals. Asian cultures, for example, defer to age; other cultures may defer to the female head of the family. Few cultures afford high status to children. In working with families during times of crisis, the crisis intervenor's status may vary from group to group. The crisis intervenor's age may be an advantage in one group but not another. In so far as possible, it would be helpful to match intervenors to students and families so that the intervenor has high status within the given culture. As crisis intervention is more directive than other forms of counseling, receiving high-status assistance is important.

By the same token, in working with a family or community during a crisis, it is important to direct communication and get cooperation from high-status individuals in that group. In working with a migrant Mexican-American family, for example, communications might first be directed to the father, thereby acknowledging his status.

Families. Family relations are always complex. Different cultures will have expanded definitions of family and have prescribed relationships that are important to acknowledge. The Western nuclear family is in contrast to the extended family and clans important in other cultures. Kinship terms such as cousin and grandfather may be used liberally and nonliterally. Family members represent a lifeline for individuals in crisis, and the intervenor would be well advised to inquire about the availability of "family."

Attitudes toward counseling. Particular attention should be paid to how mental illness and the specific crisis event are perceived by the culture of the student and family. For example, within Arabic cultures, the mentally ill are likely to be maintained within the family. Feelings of guilt may lead to overprotection, denial, or isolation, resulting in rejection of a long-term therapeutic program (Wilson, 1996). In Asian culture, where it may be viewed negatively to single out an individual as different, seeking help for a mental health problem might be perceived as bringing shame to the family (Morrow, 1988). Public health services may be viewed as more acceptable than mental health services. In Hispanic culture, having mental problems related to a crisis may be perceived as being "crazy," which is interpreted as a very negative, shameful state of being. For a comprehensive review of racial and ethnic variations in help-seeking attitudes, see Leong, Wagner, & Tata (1995). Information about these attitudes can help with referral as well as understanding what forms of help will be appreciated and used.

Group work. Group intervention may be particularly appropriate for working with linguistically and culturally diverse students or their parents whether or not they are in crisis (Esquivel, 1998). Esquivel argues that group interventions are effective because they are consistent with common aspects of many cultures: a collective orientation and an emphasis on family and group values. Since migration, poverty, and intergenerational conflict may disrupt many family resources, the group serves as a substitute for family in emphasizing cooperation, cohesiveness, and interdependence among group members.

A number of group techniques have been devised to be culturally relevant. Some notable examples are Cuento therapy, using folk tales; Hero-Heroine Modeling using biographical information; and Unitas, an intervention using older peers to recreate family (Esquivel, 1998). Although not specifically developed for crisis intervention, these techniques may be used or adapted for traumatic situations.

A group technique increasingly being used to prevent posttraumatic stress syndrome is critical incident stress debriefing (Toubiana, Milgram, Strich, & Edelstein, 1988; Wollman, 1993). This debriefing process can be adapted to different cultural groups as can the more traditional play therapy approach. Typical issues that need to be thought through in establishing a group, such as group member selection, group preparation, group composition, group goals, time orientation, and group interaction, will still have relevance. But each issue should be examined with a cultural perspective (Esquivel, 1998).

Culturally Sensitive Crisis Intervention

To conclude, we propose the following additions to the standard protocol for crisis intervention. It is tempting to consider these additions only when faced with an individual who is recognizably from a culture different from the intervenor. We believe sufficient cultural diversity is present in our population that it is appropriate to assume at the onset, that any student encountered will come from a unique culture. This unique culture must be taken into account.

Examine Fit of Individual and Cultural Norms

The first step is to learn the extent to which the student and family have become acculturated to the dominant culture. Informants can assist in this task and careful interviewing can reveal an individual's worldview.

Consider Culturally Relevant External Resources

Clergy are prime candidates for resources in many cultures, but these resources may also include an influential neighborhood leader or politician. In non-Western (and Western) cultures the family is an important system of support during times of crisis. In addition, it is important to remember that definitions of "family" do differ considerably.

Determine the Capacity of the Student and Family to Use the Resources

Not all individuals in crisis will be able to use either conventional or culturally provided resources. Attitudes toward seeking help need to be examined.

Focus on Communication

Communication is more than just using language, although sharing a language will be important in intervention. If you need to use an interpreter, be sure that communication is still taking place.

Make Appropriate Referrals

As the first, and perhaps only, person on the scene, do what you can to be helpful. Attend to physical needs, offer appropriate reassurance and anticipatory guidance, and help those in a crisis state to take positive action to facilitate coping. As soon as possible, however, facilitate an appropriate referral to a culturally appropriate helper, and follow up to determine that a connection has been made.

Conclusion

A crisis is a time when the normal world is radically disrupted. Humankind has, however, developed ways of dealing with crises. As crisis intervenors, the best we can do is to facilitate those processes that have become culturally institutionalized to help individuals cope. We must honor and respect the culturally based mechanisms available to comfort and heal those affected by traumatic events.

References

Alexander, C. M., & Sussman, L. (1995). Creative approaches to multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 375-384). Thousand Oaks, CA: Sage Publications.

Benjamin, A. (1981). *The helping interview* (3rd ed.). Boston: Houghton Mifflin.

Brock, S. E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools: A manual for building school crisis response teams*. Brandon, VT: Clinical Psychology Publishing Company (New York: Wiley).

Doll, B., & Lyon, M. A. (1998). Risk and resilience: Implications for the delivery of educational and mental health services in schools. *School Psychology Review, 27*, 348-363.

Esquivel, G. B. (1998). Group interventions with culturally and linguistically diverse students. In K. C. Stoiber & T. R. Kratochwill (Eds.), *Handbook of group intervention for children and families* (pp. 252-267). Boston: Allyn & Bacon.

Figueroa, R. A., Sandoval, J., & Merino, B. (1984). School psychology with limited-English-proficient (LEP) children: New competencies. *Journal of School Psychology, 22*, 121-143.

Frisby, C. L. (1998). Culture and cultural differences. In J. Sandoval, C. L. Frisby, K. F. Geisinger, J. D. Scheueneman, & J. R. Grenier (Eds.), *Test interpretation and diversity* (pp. 51-73). Washington, DC: American Psychological Association.

Garcia, E. E. (Ed.). (1995). *Meeting the challenge of linguistic and cultural diversity in early childhood education*. New York: Teachers College Press.

Hall, E. T. (1959). *The silent language*. Greenwich, CT: Fawcett Publications.

Kellogg, J. B. (1988). Forces of change. *Phi Delta Kappan, 70*, 199-204.

Klingman, A. (1986). School community in disaster: Planning for intervention. *Journal of Community Psychology, 16*, 205-216.

Lee, C. C., & Armstrong, K. L. (1995). Indigenous models of mental health intervention. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 441-456). Thousand Oaks, CA: Sage Publications.

Leong, F. T. L., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help-seeking attitudes. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 415-438). Thousand Oaks, CA: Sage Publications.

Lewis, O. (1970). *A death in the Sanchez family*. New York: Vintage.

Li, C., & Liu, T. C. (1993, March). How to work effectively with Asian-American families. NASP *Communiqué, 21*(6), 23-26.

Liu, T. C., & Li, C. (1994, March). *How can school psychologists best meet the needs of Hmong-Americans?* Mini-Skills Workshop conducted at the annual convention of the National Association of School Psychologists, Seattle, WA.

McIvor, R. J. (1994). Making the most of interpreters. *British Journal of Psychiatry, 165*, 268.

Morrow, R. D. (1988). Cultural differences ... be aware! *CASP Today*, *38*, 4-5.

Mitchell, J. T. (1988, November). The history, status and future of critical incident stress debriefing. *Journal of Emergency Medical Services*, 47-49, 51-52.

Pope-Davis, D. B., & Dings, J. G. (1995). The assessment of multicultural counseling competencies. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 287-311). Thousand Oaks, CA: Sage Publications.

Richardson, B. L. (1991). Utilizing the resources of the African American church: Strategies for counseling professionals. In C.C. Lee, & B. L. Richardson (Eds.), *Multicultural issues in counseling: New approaches to diversity* (pp.65-75). Alexandria, VA: American Counseling Association.

Sandoval, J., & Duran, R. P. (1998). Language. In J. Sandoval, C. L. Frisby, K. F. Geisinger, J. D. Scheueneman, & J. R. Grenier (Eds.), *Test interpretation and diversity* (pp. 181-211). Washington, DC: American Psychological Association.

Spring, J. (2000). *The intersection of cultures* (2nd ed.). Boston: McGraw-Hill.

Stack, C. (1974). *All our kin: Strategies for survival in a black community.* New York: Harper.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T. Manese, J. E., Ponterotto, J. G., & Vazquez-Nutall, E. (1998). *Multicultural counseling competencies*. Thousand Oaks, CA: Sage Publications.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, *148*, 10-20.

Toubiana, Y. H., Milgram, N. A., Strich, Y., & Edelstein, A. (1988). Crisis intervention in a school community disaster: Principles and practices. *Journal of Community Psychology*, *16*, 228-240.

Vasquez, C., & Janvier, R. A. (1991). The problem with interpreters: Communicating with Spanish-speaking patients. *Hospital and Community Psychiatry*, *42*, 163-165.

Wilson, M. (1996, August). Arabic speakers: Language and culture, here and abroad. *Topics in Language Disorders*, *16*, 65-80.

Wollman, D. (1993). Critical incident stress debriefing and crisis groups: A review of the literature. *Group*, *17*, 70-83.

Young, M. (1998). *Community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

16

危機

Developmental Aspects of Psychological Trauma and Grief

William Pfohl, Psy. D.
Western Kentucky University

Shane R. Jimerson, Ph.D.
University of California, Santa Barbara

Philip J. Lazarus, Ph.D.
Florida International University

It is well known that many children experience a traumatic event some time during their lives (Garmezy, 1993). The effects of these traumas need to be understood from a contextual framework. The effects of trauma are moderated by age, developmental level, proximity to the trauma, coping resources of the individual child (Johnson, 1998), the degree of supports available, parental reactions, and personality characteristics of each individual child. Moreover, there are factors that relate to specific traumas and influence the reaction and course of symptoms of each child. Examples of such factors include the extent of medical help available following physical injury; the shelter, or lack thereof, provided in the aftermath of a hurricane or tornado; the way a young girl is treated by the police, medical personnel, and the judicial system after a rape; the death of a loved one following an injury; or the degree that physical safety is available following a series of earthquakes. The research on developmental aspects of psychological trauma during childhood comes from decades of research on divorce, child abuse, natural disasters and, more recently, violence such as school shootings and wars (Aptekar & Boore, 1990; Finkelhor, 1995; Miller, 1998; Pynoos, 1990; Shahinfar & Fox, 1997; Terr 1983, 1988).

In this chapter we discuss developmental aspects of trauma and grief. Age is only one factor among many that modulates reactions. Therefore, it is necessary to have knowledge of the nature of the crisis event and how it is experienced in context in order to gain a complete understanding of how development influences the effects of trauma. Take, for example, a tragic bus accident that leaves a number of individuals injured or dead. One teenage girl, Molly, makes a remarkable emotional recovery and though severely physically injured she believes that God intervened to save her life. She feels grateful and blessed. Another young teenager, Joseph, of the same age, is furious at God for allowing the bus accident to occur, and later suffers from bouts of rage, depression, and anxiety. Following this same accident, a high school sophomore, Maggie, receives a great deal of emotional support from her church group and peers. While she is bedridden, her friends are constantly calling and visiting her, bringing her gifts, and doing everything in their power to make her feel special and loved. Stephanie, another sophomore girl, who is less physically injured than Maggie, feels ignored by friends. A few of them visit, yet they do not know what to say or do and offer little support. Consequently, Stephanie feels ignored and betrayed by her "so-called friends." Maggie makes a speedy emotional recovery, whereas Stephanie does not.

Psychological Trauma Experiences During Childhood

Before discussing the impact of trauma and grief, it is first necessary to differentiate between normal stressors and trauma. Normal stress, while challenging, does not typically exceed an individual's coping ability. Trauma, however, by its nature overwhelms the individual's capacity to cope. Trauma is initiated by perception of danger to an individual or a community. These events are considered "outside" of the normal life experience of some children. Trauma is different from stress in both its effects and intensity. "Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary adaptations to life" (Young, 1998, p. 1).

Children may be exposed to trauma in many different forms (Garmezy, 1993; Johnson, 1998; Toomey & Christie, 1990), including abuse (e.g., physical and/or sexual); death (e.g., of a friend, parent, close relative); war; natural disasters (e.g., hurricanes, tornadoes, earthquakes, fires, floods); shootings (in school and/or in the community); chronic illness; divorce; injuries; or accidents. Events may be chronic such as long-standing wars, abuse, or extreme poverty, or acute such as school shootings, natural disasters, or accidents.

Normal Development

To understand reactions to trauma from a developmental perspective it is necessary to have an understanding of developmental psychology. In this chapter, we focus on three theorists whose works are especially germane: Maslow, Bowlby, and Bandura.

Maslow (1968) developed a theory of human motivation. He proposed five levels or clusters of human needs and termed these a hierarchy of needs. He postulated that, if an individual's lower order needs (or *deficiency needs*) are not being met or have been disrupted, then that individual cannot satisfy higher order needs (or *growth needs*). Maslow indicated that the basic human *physiological needs* must be met first (e.g., food, shelter, clothing), followed by *safety and security needs*. Physiological and safety and security needs are considered deficiency needs. The next level of needs is *belongingness and love needs*, followed by *esteem needs*, and finally *self-actualization needs*. Maslow has suggested that deficiency needs must be dealt with before an individual can work on growth needs. Research suggests that people move back and forth among different types of needs and may even be motivated by different needs at the same time (Maslow, 1968; Thomas, 1992). While research has failed to validate the absoluteness of Maslow's model, those involved in working with trauma victims have found the theory useful. For example, following natural disasters that devastate homes and communities, children and their families must first focus on attending to their fundamental need for safety and security (Young, 1998) before moving on to satisfy higher-order needs.

Bowlby's (1963, 1980) research suggests that early *attachment* to a primary caretaker is essential for survival and normal development (Ainsworth & Bowlby, 1991). For example, his observations of orphans in Europe led him to conclude that those who did not have early social interactions were later unable to form intimate and long-lasting relationships with others. Bowlby de[illegible]eated four phases of attachment from birth to the end of childhood: (a) preattachment phase (birth to 6 weeks), (b) "attachment in the making" phase (6 weeks to 6-8 months), (c) "phase of clear cut attachment" (6-8 months to 18-24 months), and (d) "formation of reciprocal relationships" (18 months to 2 years and on). Bowlby concluded that if this attachment process is disrupted, then serious developmental problems and psychopathology might ensue. This research has important implications for crisis intervention with young children who have become orphaned as a result of war, terrorism, accidents, or disease. The loss of attachment figures may cause pathological mourning, resulting in disturbed development, emotional detachment, inability to love and trust, and depression (Bowlby, 1988). Moreover, young children who have been sexually abused, physically mistreated, and/or emotionally neglected are at grave risk and require specific comprehensive interventions to establish bonding (Levy & Orlans, 1998). Children who begin their lives with compromised and disrupted attachment are at serious risk as development unfolds. The impact of this disrupted attachment includes (a) low self-esteem; (b) needy, clingy, or psuedoindependent behaviors; (c) decompensation when faced with stress and adversity; (d) poor self-control; (e) inability to develop and maintain friendships; (f) alienation from and opposition to parents, caregivers, and other authority figures; (g) antisocial attitudes and behaviors; (h) aggression and violence; (i) lack of genuine trust, intimacy and affection; (j) negative, hopeless, and pessimistic view of self, family, and society; (k) deficits in empathy, compassion, and remorse; (l) behavioral and academic problems in school; and (m) perpetuation of the cycle of maltreatment and attachment disorder in their own children when they reach adulthood (Levy & Orlans, 1998).

Ainsworth was the most influential in advancing research on Bowlby's original ideas (Ainsworth & Wittig, 1969). In a series of studies, she examined attachment patterns in a laboratory (referred to as "the strange situation"), where a baby is initially placed in a room with the mother only. Then a stranger enters; next, the mother leaves the room; then she returns. The stranger next leaves the room; the mother then leaves, with the baby now alone; then the mother returns (Ainsworth & Wittig, 1969). The child's reaction to the separation and reunion is observed through a one-way mirror. Ainsworth studied attachment with children of all ages and cultures and found three different types of attachment patterns: one secure and two insecure/anxious patterns. *Securely* attached babies actively sought out mothers when they were distressed, maintained contact on reunion, and were easily comforted by their mothers. *Ambivalently* attached babies were extremely upset by the separation, were difficult to soothe on reunion, and resisted their mother's comfort. *Avoidantly* attached babies seemed disinterested in their mothers and often rejected them upon reunion. These three types were found cross culturally (Main & Cassidy, 1988; van Ijzendoorn & Kroonenberg, 1988). Main and her colleagues (Main & Weston, 1982; Main & Solomon, 1990) later discovered a fourth attachment pattern (i.e., disorganized/disoriented) where some children displayed both avoidant and ambivalent styles and sought closeness in strange and bizarre ways. Many of these disorganized children were found to be abused (Crittenden, 1988) and to have mothers who had experienced trauma and loss in their own early lives that they never successfully mourned or resolved. Research has repeatedly demonstrated the importance of this early relationship on subsequent development (Ainsworth, 1989; Ainsworth & Bowlby, 1991; Walsh, 1998). In working with traumatized children, it is important to consider that their relationship with a primary caregiver may affect the healthy adaptation of the child.

Bandura's social learning theory (1977, 1997) addresses the development of self-efficacy. Bandura suggests that self-efficacy is developed from an interaction process of competence, resilience, and development. He found that young children need guidance from others, but as they explore their environment, they learn what they can and cannot do. They learn to structure, regulate, and evaluate their lives (Bandura, 1997). Children learn to appraise their own capacities during this process, which leads to effective functioning. Thus, self-efficacy is an internalized appraisal of what one is capable of doing, developed through experiences with the environment. When children experience trauma, some may feel that they have very little control over what happens to them (Aptekar & Boore, 1990; Johnson, 1998; Pynoos, 1990). Bandura's social learning theory also provides a way to understand the effects of a parent's response or reaction to a traumatic event and its effect on children through modeling. Through their exploration of the world, children develop a sense of self-efficacy and internal knowledge that they can deal with difficulties. Modeling of behaviors, both positive and negative, by adults can have a direct effect on children and their response to trauma and crisis (Bandura, 1997; Cicchetti & Garmezy, 1993; Garbarino, Kostelny, & Dubrow, 1991). Research has found that a child's method of coping with trauma is correlated with their parent's coping strategies. If a parent becomes overly distressed, then the child will likely become distressed as well (Aptekar & Boore, 1990).

The Impact of Trauma on the Development of Youths

Age and developmental level influence a child's perception and understanding of trauma, the quality of the child's response, coping style and skills, and memory of the event (Handford, Mayes, Mattison, & Humphrey, 1991; Weisenberg, Schwarzwald, Waysman, Solomon, & Klingman, 1993). Furthermore, trauma and the response to the event may disrupt the child's progression of development (Perry, 1994) and may influence a child's personality style, self-concept, cognition, attention, and social skills (Nader, Goenjian, Fairbanks, & Frederick, 1990).

Age-Related Developmental Reactions

Preschoolers are most likely to exhibit decreased verbalization and cognitive confusion, increased anxious attachment behavior, and more regression following trauma (Pynoos, 1990). The preverbal child may demonstrate long-lasting "perceptual memories" entirely through his or her play or fears. For children, five years of age or younger, typical reactions can include fear of being separated from a parent, whimpering, screaming, immobility and/or aimless motion, trembling, excessive clinging, and frightened facial expressions [National Institute of Mental Health (NIMH), 2000]. Parents of young children may notice regressive behaviors such as bedwetting, fear of darkness, and thumbsucking. At this age, preschoolers are strongly affected by their parents' reactions. In addition, researchers (Scheeringa, Zeanah, Drell, & Larrieu, 1995) have described posttraumatic symptoms in infants and young children even though criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) were not sensitive enough to make this diagnosis.

School-age children are more apt to react to trauma with aggressive or inhibited behaviors and psychosomatic complaints; their behavior may be more inconsistent and reckless. It is not unusual for school-age children to obsessively retell the event (Pynoos, 1990). In addition, children at the elementary age level may show extreme withdrawal, be unable to pay attention, and exhibit disruptive behaviors. Nightmares, sleep disturbances, irritability, regressive behaviors, and outbursts of fighting are also common (Johnson, 1998; NIMH, 2000). Schoolwork often suffers following a trauma. In some instances depression, anxiety, feelings of guilt, or emotional numbing are also present (Shahinfar & Fox, 1997).

Adolescents 12- to 17-years-old may exhibit responses similar to those of adults, including flashbacks, emotional numbing, nightmares, avoidance of any reminders of the event, depression, antisocial behavior, and difficulty with peers (NIMH, 2000). Learning and concentration difficulties frequently occur (Johnson, 1998). They may fail to meet challenges of developing a positive-self concept, setting future goals, or establishing intimate relationships (Shahinfar & Fox, 1997). Adolescents often show a premature movement toward independence or increased dependence. These changes can lead them to drop out of school, marry early, radically change their career choice, or decide never to leave home (Pynoos, 1990). Adolescents may also feel extreme guilt over failure to prevent injury or loss of life and may harbor revenge fantasies that interfere with recovery from trauma.

It has been shown that the impact of a traumatic event is likely to be more severe with a child or adolescent who already had mental health problems, had been the victim of child abuse, or suffered from other forms of trauma (NIMH, 2000). In addition, youngsters who lack family support are more vulnerable and are at greater risk for poor recovery.

Contextual Variables

As previously noted, the context in which a trauma occurs has a significant impact on crisis reactions. Existing information suggests that in addition to age, factors such as intensity of exposure, degree of life threat, emotional reactivity, loss of a friend or loved one, and parental support may affect how a trauma is experienced and the eventual outcome (Garrison et al., 1995; Green, Koral, Grace, & Vary, 1991). Moreover, gender, socioeconomic status, and cultural factors also need to be taken into account. (For a detailed discussion of these contextual variables refer to Chapter 19 Identifying Individuals at Risk for Psychological Trauma.)

Exposure. Severity of exposure to a disaster is strongly related to a child's acute posttraumatic stress symptoms and anxiety. In a study of children's reactions to disaster following Hurricane Hugo, children with more severe exposure exhibited more symptoms consistent with posttraumatic stress disorder (PTSD) (Lonigan, Shannon, Finch, & Daugherty, 1991). Similar findings were also found with children after the 1989 San Francisco earthquake (Bradburn, 1991). Following the Buffalo Creek disaster in which a dam in West Virginia collapsed, Newman (1976) used interviews, projective measures, and story telling to evaluate children's responses. She reported that most of 224 children who survived the flood experienced emotional impairment. She determined that degree of disaster exposure and the child's perceptions of family reactions were significantly related to impairment. Burke, Moccia, Borus, and Burns (1986) had clinicians rate degree of anxiety, depression, and other concerns following a severe winter storm. Results indicated that children with the most exposure produced stories rated as the most distressed.

Degree of life threat. The development of severe reactions to trauma following criminal victimization is related to perception of life threat (Kilpatrick et al., 1989). In a study of adult survivors of childhood sexual abuse it was found that the risk of developing PTSD was directly related to degree of life threat of the abuse (Powell, Lipovsky, Saunders, Kilpatrick, & Resnick, 1990). In a seminal study, Terr (1981) interviewed 23 of 26 children who had been kidnapped and buried in a trailer truck in Chowchilla, California. She noted that every child interviewed had symptoms of "psychic trauma." She reported that all the children had kidnapping-related fears. She found that 39% evidenced nightmares, hypervigilance, and panic attacks associated with trauma-related stimuli and 61% evidenced reenactment of the kidnapping during "posttraumatic play." Terr (1983) later re-interviewed 25 of the children 4 years after the kidnapping. She found that all continued to have PTSD responses. Of these children, 92% expressed a sense of foreshortened future and more than 50% continued to have dreams in which they died.

321

Loss. In disaster studies, it has been shown that the severity of posttraumatic stress reactions correlates with interpersonal loss (Goenjian, Pynoos, Steinberg, & Najarian, 1995; Milgram, Toubiana, Klingman, Raviv, & Goldstein, 1988; Pynoos et al., 1987). Posttraumatic stress responses have been reported in children who suffered traumatic loss of their parents (Malmquist, 1986; Pynoos & Eth, 1984), siblings (Applebaum & Burns, 1991), and peers (Milgram et al., 1988; Pynoos et al., 1987). In a study that examined reactions of bereaved children after the Oklahoma City bombing, researchers (Pfefferbaum et al., 1999) evaluated youths who had experienced loss across a range of relationships that included immediate and extended family members, friends, and acquaintances. It was found on a measure of posttraumatic stress that bereaved youths had significantly higher symptomatology than did nonbereaved youths, and individuals who lost an immediate family member had the highest number of symptoms.

Parents' reactions and family influences. Aptekar and Boore (1990) reviewed the literature on disasters and their effects on children and concluded that one of the most influential factors was how the parents reacted. They found much less stress in families in which parents felt comfortable expressing their distress and provided support for their children. McFarlane (1987) reported that the effects of the trauma were greater in children when parents themselves suffered from severe posttraumatic stress and were otherwise not able to provide emotional support. In addition, McFarlane found that separation from parents immediately after a natural disaster, ongoing maternal preoccupation with the event, and altered family functioning were more predictive of symptom development in children after disaster than were loss or exposure.

Researchers have also found that parents are not always aware of their child's reactions to trauma (Aptekar & Boore, 1990; Prinstein, LaGreca, Vernberg, & Silverman, 1996). For instance, following the nuclear incident at Three Mile Island, many children were found to have more symptoms than their parents were aware of and to have more symptoms than did the parents themselves. This finding may be related to parental denial of their children's problems, which prevents them from discussing issues openly. A major implication of this finding is that information about children's reactions needs to be obtained from the children themselves. In addition, it needs to be noted that following trauma experienced by children, teachers underreported psychological problems in children even more so than did parents (Udwin, 1993).

Gender. It has been found that gender influences a child's coping style, the availability and use of support, and expectations for recovery (Pfefferbaum, 1997). Large-sampled studies of gender differences among children generally found girls more symptomatic than boys (Green et al., 1991; Lonigan et al., 1991; Shannon, Lonigan, Finch, & Taylor, 1994). For example, Garrison and colleagues (1995) reported higher rates of PTSD in adolescent girls than in boys following Hurricane Andrew, and this appears consistent with other research findings. Researchers (Shahinfar & Fox, 1997) found developmental and gender differences among children 5 to 12 years old who witnessed a school accident. Boys took longer to recover than girls, had sleep disturbances, fighting, and fear responses. Girls had startle reactions and asked more questions about the accident. Boys typically experience more externalizing behaviors, while girls experience more internalizing behaviors. This difference has been noted in most gender studies of pathology. No gender differences have been found in preschool children (Shahinfar & Fox, 1997). Boys and girls have different abilities in recalling the event. Girls are also more likely to suffer feelings of helplessness and severe stress reactions than males (Shahinfar & Fox, 1997).

Socioeconomic and cultural factors. Few studies have examined racial, ethnic, or cultural differences as related to trauma. Studies of large populations of youths exposed to natural disasters use different methodologies and report contradictory results with respect to racial differences (Garrison et al., 1995; Lonigan et al., 1991; Shaw, Applegate, Tanner, & Perez, 1995). Some reports, however, have documented high rates of stress responses in youths residing in communities characterized by high crime and violence (Fitzpatrick & Boldizar, 1993; Martinez & Richters, 1993). Yet at this time there is no convincing evidence that children respond differently to trauma on the basis of their racial, cultural, or ethnic characteristics.

Reactions to a trauma do not inevitably lead to psychopathology or full-blown PTSD symptoms. The intensity of the stressor; degree of life threat; age of the youth; child's stress history; sense of mastery over the event; bereavement issues; parental support; individual coping style; gender; cultural, racial, and ethnic issues; and socioeconomic status are all factors that need to be taken into account in order to appreciate how trauma affects development.

Developmental Aspects of Grief

Bowlby (1960) described grief as "the sequence of subjective states that follow loss and accompany mourning" (p. 11). Grief is increasingly recognized as a salient developmental task faced by many youths (Corr, 1996). Clinicians and theorists have highlighted the significance of loss during childhood on subsequent development (Bowlby, 1980, 1982; Corr & Balk, 1996; Corr & Corr, 1996; Worden, 1996) and have also generated literature to assist practitioners in helping bereaved children (Grollman, 1967, 1995; Webb, 1993; Wolfelt, 1983; the latter is addressed in Chapter 32, Children's Grief, in this volume). Although it is necessary to appreciate individual differences among bereaved youths, it also has been highlighted that an understanding of death depends on one's developmental level, including cognitive and socioemotional development, and past experiences (Bertoia & Allan, 1988). One of the most common oversights of adults working with bereaved youths is assuming that children have the same understanding of death as adults. Available literature reflects the importance of considering the potential developmental implications of early loss in addition to the developmental considerations below regarding children's understanding of death.

In regards to the significance of early loss, Bowlby (1980) states: "Loss of a loved person is one of the most intensely painful experiences any human being can suffer" (p. 7). Furthermore, children and adolescents appear to be even more sensitive to the conditions that follow a loss than are adults (Bowlby, 1980). Although loss includes a variety of experiences, herein, the emphasis is on important developmental considerations when working with youths following the death of a close or special person. Grief has been characterized as the emotional and behavioral experiences in response to a loss.

Following a loss, a variety of behaviors and feelings may accompany grief in children, including denial, panic, anger, guilt, sadness, anxiety, preoccupation, hyperactivity, short attention span, withdrawal, and repression of feelings (Huntley, 1991). Any of these common behaviors and feelings may produce problems later if they persist and if the child does not cope with the loss in a healthy way. The degree to which one effectively copes with a loss will be contingent on many developmental and situational factors (e.g., child's characteristics, support of family, friends, and school). Clearly, there are many variations of healthy mourning and grief responses.

Deutsch (1937) proposed that over time "every unresolved grief is given expression in one form or another" (quoted in Bowlby, 1963, p. 531). Thus, if a child does not experience "healthy mourning," subsequent development may be negatively affected. Mental health concerns such as persisting anxiety, hopes of reunion with the deceased, desire to die, persisting blame and guilt, aggressive and destructive outbursts, and compulsive caregiving and self-reliance have each been suggested by Bowlby (1982) to be outcomes associated with disordered mourning. The above ideas are consistent with a transactional model of development (Sameroff & Chandler, 1975) emphasizing the importance of one's early experiences influencing subsequent development. A central tenet of the transactional model is that ongoing adaptations are a result of one's developmental history and current circumstances (see Jimerson, 1999, for a brief overview of this orientation). Thus, the grief experiences of children are important for mental health and adaptation in the present and the future. The grief experience of a child is highly associated with his or her emerging understanding of death. It is important for school mental health professionals to recognize important developmental considerations in children, such as their understanding of the concept of death, as well as gender, cultural considerations, and cognitive and social developmental levels.

Understanding Death: Developmental Considerations

There are developmental differences in how children of different ages understand and interpret death (Anthony, 1972; Nagy, 1948; Speece & Brent, 1996). Levels of cognitive and social development and life experiences affect children's understanding about death (Baker & Sedney, 1996). Research has yielded four important components of understanding the concept of death: (1) universality, (2) irreversibility, (3) nonfunctionality, and (4) causality (Speece & Brent, 1984). The following provides an overview regarding developmental trends in understanding each of these components and important cognitive and socioemotional developmental considerations. Although ages are included in the following discussion, children vary significantly and it is important to listen to each child to comprehend his or her understanding of death.

Universality. Universality refers to the understanding that all living things eventually die. Universality includes three closely related dimensions: all inclusiveness (e.g., every living thing will die), inevitability (e.g., each living thing will die eventually), and unpredictability (e.g., death may occur at any moment to any living thing). In general, during the first five years of life, children do not understand the universality of death. Although some children between the ages of five and nine understand that death is universal, for many children the concept of universality remains illusive during the first decade of life. Regarding inclusiveness, younger children are more likely than older children to think that death is avoidable if one is especially clever or lucky (Nagy, 1948). Younger children are also more likely to indicate that death will occur in the very distant future, thus failing to understand the unpredictable nature of death (Lee, 1987; Swain, 1979). Kastenbaum (1967) reported that young children seem to believe that death is accidental (rather than inevitable) and they often assume that they themselves will not die. Whereas early research suggested that children attribute the possibility of death to all other people before they extend it to themselves (Schilder & Wechsler, 1934), more recent research suggests that most children understand their own personal mortality before they understand that all other people die (Robinson, 1977; Speece & Brent, 1992; Steiner, 1965). By age 10, children usually begin to understand that death is universal and inevitable (Grollman, 1967; Kastenbaum, 1967; Lonetto, 1980). A child's beliefs regarding the universality of death will undoubtedly influence grief reactions. It is important that adults do not assume a child understands the universality of death.

Irreversibility. Irreversibility refers to the understanding that once the physical body dies, it cannot become alive again. Younger children are more likely to view death as reversible or temporary, not fully understanding the irrevocability and finality of death. Instead, younger children often understand death as taking a trip or going to sleep (it should be noted that often this understanding has resulted from information provided by an adult, for instance, explaining the death of a grandparent as "Grandma is on a long trip" or "Grandpa is in a deep sleep"). Thus, according to these youngsters death is not permanent (Anthony, 1972; Melear, 1973; Saravay, 1991). Children often believe that death can be reversed spontaneously, through wishful thinking, praying, or magical and medical interventions (Speece & Brent, 1992; Weininger, 1979). Many professionals working with young children have needed to address the fact that prayers and other behaviors will not bring a deceased loved one back. By age 10, as children enter the primary grades, most understand the concept of irreversibility (e.g., that death is final; Grollman, 1967; Kastenbaum, 1967; Lonetto, 1980). A child's beliefs regarding the irreversibility of death will likely influence grief reactions and coping following a loss. It is important that adults do not assume that a child understands the irreversibility of death.

Nonfunctionality. Nonfunctionality refers to the understanding that once a living thing dies, all of the typical life capabilities of the living thing (e.g., walking, eating, thinking) cease. It appears that younger children are more likely than older ones to think that the dead continue to be able to perform various functions (Hoffman &

Strauss, 1985; Kane, 1979). Such functions include both internal (e.g., thinking, knowing) and external (e.g., walking, eating) functions. Adults working with bereaved youths may receive questions from children addressing the need for the deceased person to eat or how the deceased person feels. Clearly, such queries are active efforts to seek further information related to the nonfunctionality component of understanding death. In general, Kane (1979) found that children at any given age are more likely to understand the cessation of external functions than internal functions. While this area has received less attention than others in the research, it appears that an understanding of nonfunctionality is often present by age 11 (Hoffman & Strauss, 1985; Lonetto, 1980). A child's ideas regarding the nonfunctionality of death will clearly influence coping and grief responses following a loss. It is important that adults do not assume a child understands the nonfunctionality of death.

Causality. Causality refers to the abstract and realistic understanding of internal and external causes of death—abstract in the sense that the possible causes are not restricted to a particular individual or event, but are applicable to all living things in general, and realistic in the sense that the specified causes would be generally accepted by most mature adults as valid causes of death. For example, most adults would accept that a person may die from a disease such as cancer or an accident involving damage to internal organs; however, most adults would not accept that bad behavior would cause a death. Research suggests that younger children are more likely than older children to provide unrealistic causes of death (e.g., bad behavior, stepping on cracks, eating a specific food) or to list specific concrete causes (e.g., guns, driving fast; Devereux, 1984; Koocher, 1973; Robinson, 1977). It appears younger children are also more likely to lack an understanding that death may result from a failure of internal bodily organs or systems (Candy-Gibbs, Sharp, & Petrum, 1985). Younger children are more likely to focus on external causes (e.g., violence) than internal causes (e.g., kidney failure, cancer) (Kane, 1979; Karpas, 1986). Understanding of the causality component of the concept of death often continues to develop through early adolescence. Children's ideas regarding various causes of death influence grief reactions and coping following a loss. It is important that adults do not assume a child has an adult understanding of causes of death.

Age and Development

It should be recognized that age by itself explains very little regarding children's grief, as age is a rather general, omnibus index of a wide range of correlated environmental and biological variables. The specific age at which children have been reported to achieve an adult understanding of the key components of death has ranged from 5 to 12 years and older (Speece & Brent, 1984). Most studies report that at around age 10 years children understand each of the key components of the death concept (e.g., universality, irreversibility, nonfunctionality, and causality; Anthony, 1972; Kastenbaum, 1967; Nagy, 1948). It should be recognized that because children vary, so does their understanding of death and their grief experiences. Development is an individual process and we must caution about the use of specific age references. These age references are included to give a sense of when components are likely to be present; however, the main point is that each of these dimensions is important and will gradually emerge across development during childhood. Thus, we emphasize that a youth's understanding of death may only be understood through listening to each child share his or her ideas and grief experiences.

Cognitive and Socioemotional Development Considerations

A number of studies have demonstrated concordance between children's understanding of death and Piaget's (1954) general theory of cognitive development (Cotton & Range, 1990; Gorman, 1983; Koocher, 1973; Krasnow, 1993; Mahon, 1992; Reilly, Hasazi & Bond, 1983; Walco, 1982, 1984; Weber, 1981). It is during Piaget's concrete operational stage (ages 7 to 10), when reduced egocentricity and improved capacity for reasoning are present, that children tend to develop a more adult understanding. As children border Piaget's formal operational stage (ages 11 to 12), their thinking becomes truly logical, able to handle multiple variables at once, and capable of dealing with abstract ideas. Likewise, their understanding of death is often consistent with an adult understanding. Analyses of children's drawings at different ages suggest a shift to the representation of death in abstract terms at around age 12 (Lonetto, 1980). However, it appears that achievement of a specific Piagetian level of cognitive development (e.g., concrete operations or formal operations) is not necessary for understanding irreversibility, nonfunctionality, universality, or causality, because several studies demonstrate that preoperational children often understand a particular component (Kalmbach, 1979; Reilly, Hasazi, & Bond, 1983). It is suggested that the basic understanding of death that develops in early and middle childhood serves as a foundation for the development of a more complex concept during late childhood and adulthood (Kosko & Sartoru, 1993). As the cognitive and socioemotional domains are increasingly interrelated across development, this concept continues to be enriched and elaborated through one's experiences with life and death.

When children's vocabulary develops they are likely to use words such as die and dead; however, they often do not comprehend the meaning of these words. Thus, as young children's understanding of death evolves, they are dependent on adults, peers, books read to them, and television to provide information (Huntley, 1991). Throughout development, their understanding of what it is to be alive also enhances children's understanding of death. Between the ages of 9- and 12-years, children's understanding of what is alive moves from thinking that anything that is capable of spontaneous movement is alive, to an understanding that clouds, stars, and rivers are not alive. Typically, children of this age develop an adult view of living and not living (Kastenbaum, 1967), often limiting the term "alive" to plants and animals. At this age, children are very interested and able to understand the facts surrounding death, but are less able to comprehend the feelings (Huntley, 1991).

Whereas young children may not have an adult understanding of death, they do react to loss. Children's grief reactions are a combination of their own cognitive and socioemotional developmental levels and changes in their lives. Although disagreement about the specific age exists, most researchers and practitioners agree that even young children do grieve, even during the first few years of life (Bowlby, 1963, 1980; Deutsch, 1937; Furman, 1964). While one's "understanding" of death will influence grief reactions, the ability to grieve depends on one's ability to "feel." "Therefore, any child mature enough to love is mature enough to grieve" (Wolfelt, 1983, p. 20). Thus, even though a young child may not have a fully developed understanding of death, and may lack the terms associated with internal feelings (e.g., sad, anxious, guilty), it is apparent that they will be impacted by the loss of a close or special person.

Gender Differences

Gender emerges as the second most popular variable included in studies of bereaved youths (age is the first). The gender of a child has been reported to be related to grief responses. Silverman and Worden (1992) reported that girls were more comfortable expressing their feelings and hypothesized that this was related to early socialization. Results of another study suggest that girls were more concerned about their own safety and that of the surviving parent than were boys, and boys experienced more learning difficulties than did girls (Worden, 1996). It should be noted that, in general, studies report few gender differences in emotional and behavioral grief responses.

With few exceptions, studies have found no differences in girls' and boys' understanding of death (Carlson, Asarnow, & Orbach, 1987; Florian, 1985; Florian & Kravetz, 1985; Jenkins & Cavenaugh, 1985; Karpas, 1986; Krasnow, 1993; Lee, 1987; Ramsey, 1986; Schonfeld & Kappelman, 1990; Seide, 1983; Sisson, 1987; Walco, 1982; Wass & Towry, 1980). Two studies that did find a relationship between children's gender and their understanding of death found (a) in a Chinese sample, that boys were less likely than girls to indicate a belief in the afterlife (Hui, Chan, & Chan, 1989), and (b) that boys were more likely than girls to describe death as an irreversible biological process (Hargrove, 1979).

In regards to the death of a parent, Worden (1996) reports that children who lost an opposite-gender parent reported more health problems and felt more fear for the safety of the surviving parent. The loss of a same-gender parent was associated with greater identification with the deceased in the early months following the death. These children also saw themselves as more mature one year following the death (Worden, 1996). Again, it is important to recognize that very few gender differences emerged in comparisons of children's grief responses and understanding of death.

Cultural Differences

It is also important to note that individual differences are also impacted by cultural backgrounds (Irish, Lundquist, & Nelson, 1993). Children from different cultural backgrounds have varying beliefs about death, which will influence their reactions to a death. In addition, formal and informal rituals following a death vary across cultures and these also influence the grief response. Sometimes religious practices and mourning rituals influence the child's grief expression and experience. Most thanatologists recommend that children be allowed to participate in religious and cultural traditions associated with death (Rando, 1991; Wolfelt, 1983). We often have limited knowledge about other culture's beliefs regarding death (Grabowski & Frantz, 1993; Oltjenbruns, 1991). Thus, it is important to ask rather than assume to know about the families' beliefs and rituals. For example, there are variations among broad populations such as Hispanic students who may identify with a Cuban, Mexican, Puerto Rican, or other Latin American culture. Recognizing these cultural complexities is another important developmental consideration.

Studies of ethnicity and children's understanding of death concepts in the United States have not demonstrated differences when comparing Black, Caucasian, and Hispanic children (Mahon, 1992; Schonfeld & Kappelman, 1990; Wass & Towry, 1980). Comparisons of children in the United States to children in Israel suggest that Israeli children have a more mature understanding of death concepts (Schonfeld & Smilansky, 1989). Other studies have compared children from the United States and Brazil (Wass, Guenther, & Towry, 1979), the United States and Sweden (Wass, Guenther, & Towry, 1979), the United States and Jordan (Ramsey, 1986), and Canada and Sweden (Gorman, 1983). Studies examining children's understanding of death concepts across countries have yielded some differences; however, no general conclusions are possible at this time.

Studies examining the effects of religion on children's understanding of death concepts have found very few significant differences (Karpas, 1986; Sisson, 1987). Some report differences regarding beliefs in an afterlife, but not with the understanding of personal mortality, natural causation, inevitability, or unpredictability (Candy-Gibbs et al., 1985; Krasnow, 1993). Studies examining religion outside of the United States have found a greater impact of religion (Hui, Chan, & Chan, 1989; Ramsey, 1986). For example, in a study of Israeli children, differences in understanding of death concepts were reported among groups of Jewish, Christian, Muslim, and Druze children (Florian & Kravetz, 1985).

Anthropologists have long been aware of variations in mourning, rituals, and definitions of death across different cultures. While the available research does not provide specific guidelines to attend to when working with grieving children from diverse backgrounds, it is important that we appreciate the influence of children's developmental history on their grief reactions and understanding of death concepts. Resources are available to assist with understanding various perspectives on death and grief (e.g., Doka & Davidson, 1998). A general awareness of the variety of variables influencing grief reactions of bereaved children, including, age, gender, developmental level, cultural and religious practices and beliefs, family factors, and internal and external characteristics and support (Rando, 1984; Worden, 1991), is important for those working with bereaved youths.

Summary

Children respond to trauma in many different ways, depending on their cognitive and behavioral capacities at both the time of the trauma and the time of the expression of posttraumatic stress (Shahinfar & Fox, 1997). Healthy coping following an early trauma may be facilitated by an assortment of protective factors. The nature of the trauma, the premorbid state of the individual, the child's temperament, the developmental capacity of the child (social, cognitive, and behavioral), the parents' reaction, availability of a strong, caring family support network, and the community's ability to provide the necessary support after the event contribute greatly to the potential for healthy coping following a traumatic event or early loss.

There is still much to be learned about trauma and its effects on normal development. We are aware that trauma does affect children and adolescents, and there appears to be a consensus on assorted reactions that may be manifested across various developmental levels. We know relatively little about the short- and long-term effects of the recent episodes of school violence on children. It may be similar to that found in other settings. A child's response to trauma may be influenced by their parents' response to previous trauma and it may be influenced by a unique behavioral style that parents pass along to their children (Shahinfar & Fox, 1997).

Finally, an awareness of the broad developmental sequence in children's understanding of death can be helpful for adults who work with bereaved children (Dyregrov, 1991). If we are sensitive to how children think about death and what they understand, and consider each child's cognitive and socioemotional development, we will be better prepared to work with bereaved youths. It is important to listen to children as they explain their understanding of a loss and their grief experience, rather than assume we know their knowledge and experience based on their age. Attending to individual differences is an important prerequisite in determining an appropriate course of action to facilitate healthy mourning of bereaved youths (Lehmann, Jimerson, & Gaasch, 2001). This includes consideration of cultural and spiritual rituals and family factors that will influence a child's understanding following the loss and also influence the child's grief reactions. Finally, it is important to recognize that development is a process, which occurs across the life span, and it should be anticipated that children will likely revisit early loss experiences. Thus, grief is not an event with a specific start and finish, but rather is a process that will be incorporated and experienced across the life span.

References

Ainsworth, M. D. (1989). Attachment beyond infancy. *American Psychologist* 44, 709-716.

Ainsworth, M. D., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist*, 46, 333-341.

Ainsworth, M. D. S., & Wittig, B. A. (1969). Attachment and the explanatory behavior of one year olds in a strange situation. In B. M. Foss (Ed.), *Determinations of infant behavior* (Vol. 4, pp. 113-126). London: Methuen.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anthony, S. (1972). *The discovery of death in childhood and after.* New York: Basic Books.

Applebaum, D. R., & Burns, G. C. (1991). Unexpected childhood death: Post traumatic stress disorders in surviving siblings and parents. *Journal of Clinical Child Psychology*, 20, 114-120.

Aptekar, L., & Boore, J. A. (1990). The emotional effects of disaster on children: A review of the literature. *International Journal of Mental Health*, 19, 77-90.

Baker, J., & Sedney, M. (1996). How bereaved children cope with loss: An overview. In C. Corr & D. Corr (Eds.), *Handbook of childhood death and bereavement* (pp. 109-130). New York: Springer Publishing.

Bandura, A. (1977). *Behavior modification.* New York: Freeman.

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York: Freeman.

Bertoia, J., & Allan, J. (1988). School management of the bereaved child. *Elementary School Guidance and Counseling*, 23, 30-38.

Bowlby, J. (1960). Grief and mourning in infancy and early childhood. *Psychoanalytic Study of Children*, 15, 9-52.

Bowlby, J. (1963). Pathological mourning and childhood mourning. *Journal of the American Psychoanalysis Association*, 11, 500-541.

Bowlby, J. (1980). *Attachment and loss: Loss, sadness, and depression.* New York: Basic Books.

Bowlby, J. (1982). *Attachment and loss: Attachment.* New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Bradburn, I. S. (1991). After the earth shook: Children's stress responses 6-8 months after a disaster. *Journal of the American Academy of Child Psychiatry*, 139, 1010-1014.

Burke, J. D., Moccia, P., Borus, D. F., & Burns, F. J. (1986). Emotional distress in fifth grade children's behavior after a natural disaster. *Journal of the American Academy of Child Psychology*, 25, 536-541.

Candy-Gibbs, S. E., Sharp, K. C., & Petrum, C. J. (1985). The effects of age, object, and cultural/religious background on children's concepts of death. *Omega*, 15, 329-346.

Carlson, G. A., Asarnow, J. R., & Orbach, I. (1987). Developmental aspects of suicidal behavior in children: I. *Journal of the American Academy of Child & Adolescent Psychiatry*, *26*, 186-192.

Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology*, 5, 497-502.

Corr, C. (1996). Children, development, and encounters with death and bereavement. In C. Corr & D. Corr (Eds.), *Handbook of childhood death and bereavement* (pp. 3-28). New York: Springer Publishing.

Corr, C., & Balk, D. (1996). *Handbook of adolescent death and bereavement*. New York: Springer Publishing.

Corr, C. A., & Corr, D. M. (Eds.) (1996). *Handbook of childhood death and bereavement*. New York: Springer Publishing.

Cotton, C. R., & Range, L. M. (1990). Children's death concepts: Relationship to cognitive functioning, age, experience with death, fear of death, and hopelessness. *Journal of Clinical Child Psychology*, *19*, 123-127.

Crittenden, P. M. (1988). Relationship at risk. In J. Blesky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 136-176). Hillsdale, NJ: Erlbaum.

Deutsch, H. (1937). Absence of grief. *Psychoanalytic Quarterly*, 6, 12-22.

Devereux, W. C. (1984). Children's understanding of the physical realities of death. Doctoral dissertation, The University of North Dakota. *Dissertation Abstracts International*, 44, 3523B.

Doka, K., & Davidson, J. (1998). *Living with grief: Who we are, how we grieve*. Philadelphia, PA: Brunner and Mazel.

Dyregrov, A. (1991). *Grief in children: A handbook for adults*. London: Jessica Kingsly.

Finkelhor, D. (1995). The victimization of children: A developmental perspective. *American Journal of Orthopsychiatry*, 65, 177-193.

Fitzpatrick, K. M., & Boldizar, J. P. (1993). The prevalence and consequences of exposure to violence among African-American youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *32*, 424-430.

Florian, V. (1985). Children's concept of death: An empirical study of a cognitive and environmental approach. *Death Studies*, 9, 133-141.

Florian, V., & Kravetz, S. (1985). Children's concepts of death: A cross-cultural comparison among Muslims, Druze, Christians, and Jews in Israel. *Journal of Cross Cultural Psychology*, *16*, 174-189.

Furman, R. A. (1964). Death and the young child: Some preliminary considerations. *Psychoanalytic Study of the Child*, *19*, 321-333.

Garbarino, J., Kostelny, K., & Dubrow, N. (1991). What children can tell us about living in danger. *American Psychologist* 46, 376-383.

Garmezy, N. (1993). Children in poverty: Resilience despite risk. *Psychiatry*, 56, 127-136.

Garrison, C. Z., Bryant, E. S., Addy, C. C., Spurrier, P. G., Freedy, J. R., & Kilpatrick, D. C. (1995). Post-traumatic stress disorder in adolescents after Hurricane Andrew. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34, 1193-1201.

Goenjian, A. K., Pynoos, R. S., Steinberg, A. M., & Najarian, L. M. (1995). Psychiatric comorbidity in children after the 1988 earthquake in Armenia. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1174-1184.

Gorman, M. C. T. (1983). Children's concepts of death and animistic thinking. Doctoral dissertation, York University. *Dissertation Abstracts International, 44*, 2540B.

Grabowski, J., & Frantz, T. (1993). Latinos and Anglos: Cultural experiences of grief intensity. *Omega, 26*, 273-285.

Green, B. L., Korol, M., Grace, M. C., & Vary, M. G. (1991). Children and disaster: Age, gender and parental effects on PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 30*, 945-951.

Grollman, E. (Ed.). (1967). *Explaining death to children*. Boston: Beacon Press.

Grollman, E. (1995). *Bereaved children and teens: A support guide for parents and professionals*. Boston: Beacon Press.

Handford, H. A., Mayes, S. D., Mattison, R. E., & Humphrey, F. J. (1991). Child and parent reaction to the Three Mile Island nuclear accident. *Journal of the American Academy of Child Psychiatry, 5*, 589-599.

Hargrove, E. L. (1979). An exploratory study of children's ideas about death, with a view toward developing an explanatory model. Doctoral dissertation, University of North Texas. *Dissertation Abstracts International, 40*, 1688A.

Hoffman, S. I., & Strauss, S. (1985). The development of children's concepts of death. *Death Studies, 9*, 469-482.

Hui, C., Chan, I. S., & Chan, J. (1989). Death cognition among Chinese teenagers: Beliefs about consequences of death. *Journal of Research in Personality, 23*, 99-117.

Huntley, T. (1991). *Helping children grieve: When someone they love dies*. Minneapolis: Augsburg.

Irish, D., Lundquist, K., & Nelson, V. (1993). *Ethnic variations in dying, death, and grief: Diversity in universality*. Washington, DC: Taylor & Francis.

Jenkins, R. A., & Cavenaugh, J. C. (1985). Examining the relationship between the development of the concept of death and overall cognitive development. *Omega, 16*, 193-199.

Jimerson, S. (1999). On the failure of failure: Examining the association of early grade retention and late adolescent education and employment outcomes. *Journal of School Psychology, 37*, 243-272.

Johnson, K. (1998). *Trauma in the lives of children: Crisis and stress management techniques for counselors, teachers, and other professionals* (2nd ed.). Alameda, CA.: Hunter House.

Kalmbach, C. A. (1979). The relationship between the cognitive level of the child and his/her conception of death. *Doctoral dissertation, The Florida State University. Dissertation Abstracts International, 39*, 5518B.

Kane, B. (1979). Children's concepts of death. *Journal of Genetic Psychology, 134*, 141-153.

Karpas, R. J. (1986). Concept of death and suicidal behavior in children and adolescents. Doctoral dissertation, Pace University. *Dissertation Abstracts International, 47*, 3136B.

Kastenbaum, R. (1967). The child's understanding of death: How does it develop? In E. A. Grollman (Ed.), *Explaining death to children* (pp. 89-109). Boston: Beacon Press.

Kilpatrick, D. G., Saunders, B. E., Amick-McMullen, A., Best, C. L., Veronen, L. J., & Resnick, H. S. (1989). Victim and crime factors associated with the development of crime related post-traumatic disorder. *Behavior Therapy, 20*, 199-214.

Koocher, G. P. (1973). Childhood, death and cognitive development. *Developmental Psychology, 9*, 369-375.

Kosko, B., & Sartoru, I. (1993). Fuzzy logic. *Scientific American, 267*, 76-81.

Krasnow, J. E. (1993). The impact of experience on children's conceptions of death. Doctoral dissertation, State University of New York at Buffalo. *Dissertation Abstracts International, 53*, 4976B.

Lee, W. (1987). Children's conceptions of death: A study on age and gender as factors in concept development. Doctoral dissertation, Harvard University. *Dissertation Abstracts International, 48*, 2119B.

Lehmann, L., Jimerson, S., & Gaasch, A. (2001). *Grief support group curriculum facilitators handbook.* Philadelphia: Brunner & Routledge.

Levy, T. M., & Orlans, M. C. (1998). *Attachment, trauma and healing: Understanding and treating attachment disorders in children and families.* Washington, DC: CWLA Press.

Lonetto, R. (1980). *Children's conceptions of death.* New York: Springer Publishing.

Lonigan, C. J., Shannon, M. P., Finch, A. J. Jr., & Daugherty, T. K. (1991). Children's reaction to a natural disaster: Symptoms severity and degree of exposure. *Advances in Behavioral Research and Therapy, 13*, 135-154.

Mahon, M. M. (1992). The relationship between the experience of sibling death from trauma and acquisition of an accurate concept of death. Doctoral dissertation, University of Pennsylvania. *Dissertation Abstracts International, 53*, 2248B.

Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a 1-month period. *Developmental Psychology, 24*, 415-426.

Main, M., & Solomon, J. C. (1990). Procedures for identifying infants as disorganized/disordered during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 121-160). Chicago: University of Chicago Press.

Main, M., & Weston, D. (1982). Avoidance of the attachment figure in infancy: Descriptions and interpretations. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior* (pp. 31-59). New York: Basic.

Malmquist, C. P. (1986). Children who witness parental murder: Post traumatic aspects. *Journal of the American Academy of Child Psychiatry, 25*, 320-325.

Martinez, P., & Richters, J. E. (1993). The National Institute of Mental Health community violence project II: Children distress symptoms associated with violence exposure. *Psychiatry, 56*, 22-35.

Maslow, A. H. (1968). *Toward a psychology of being.* Princeton, NJ: Van Nostrand.

McFarlane, A. C. (1987). Post traumatic phenomena in a longitudinal study of children following a natural disaster: The longitudinal effects of post-traumatic morbidity. *Australian New Zealand Journal of Psychiatry, 21*, 210-218.

Melear, J. (1973). Children's conceptions of death. *Journal of Genetic Psychology, 123*, 359-360.

Milgram, N. A., Toubiana, Y. H., Klingman, A., Raviv, A., & Goldstein, I. (1988). Situational exposure and personal loss in children's acute and chronic stress reactions to a school bus disaster. *Journal of Traumatic Stress, 1*, 339-352.

Miller, T. W. (Ed.). (1998). *Children of trauma: Stressful life events and their effects on children and adolescents*. Madison: International University Press.

Nagy, M. (1948). The child's theories concerning death. *Journal of Genetic Psychology, 73*, 3-27.

Nader, K. O., Goenjian, A. K., Fairbanks, C., & Fredrick, C. (1990). Children's PTSD reactions one year after a sniper attack at school. *American Journal of Psychiatry, 147*, 1526-1530.

Newman, C. (1976). Children of disaster: Clinical observations at Buffalo Creek. *American Journal of Psychiatry, 133*, 306-312.

National Institute of Mental Health. (2000). *Helping children and adolescents cope with disasters: Fact sheet*. Available Online: www.nimh.nih.gov

Oltjenbruns, K. A. (1991). Positive outcomes of adolescents' experience with grief. *Journal of Adolescent Research*, 6, 43-53.

Perry, B. D. (1994). Neurobiological sequelae of childhood trauma. PTSD in children. In M. M. Murburg (Ed.), *Catecholomine function in post trauma stress disorder: Emerging concepts* (pp. 235-255). Washington, DC: American Psychiatric Press.

Pfefferbaum, B., Nixon, S. J., Tucker, P. M., Tivis, R. D., Moore, V. L., Gurwitch, R. H., Pynoos, R. S., & Geis, H. K. (1999). Post traumatic stress response in bereaved children after the Oklahoma City bombing. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1372-1383.

Pfefferbaum, B. (1997). Post traumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 1503-1509.

Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.

Powell, M., Lipovsky, J., Saunders, B., Kilpatrick, D., & Resnick, H. (1990, November). *Risk factors in women sexually abused in childhood*. Paper presented at the 25th annual meeting of the Association for the Advancement of Behavior Therapy, San Francisco, CA.

Prinstein, M. J., LaGreca, A. M., Vernberg, E. M., & Silverman, W. K. (1996). Children's coping assistance: How parents, teachers, and friends help children cope after a natural disaster. *Journal of Clinical Child Psychology, 25*, 463-475.

Pynoos, R. S. (1990). Post-traumatic stress disorder in children and adolescents. In B. D. Garfinkel, G. A. Carlson, & E. B. Weller (Eds.), *Psychiatric disorders in children and adolescents* (pp. 48-63). Philadelphia: W. B. Saunders.

Pynoos, R. S., & Eth, S. (1984). The child as witness to homicide. *Journal of Social Issues, 40*, 87-108.

Pynoos, R. S., Fredrick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and post traumatic stress in school age children. *Archives of General Psychiatry*, *44*, 1057-1063.

Ramsey, V. O. (1986). The relationship of age, sex, experience, religion, and culture of children's concepts of death: A study of American and Palestinian children. Doctoral dissertation, Texas Woman's University. *Dissertation Abstracts International*, *47*, 2881A.

Rando, T. A. (1984). *Grief, dying, and death: Clinical interventions for caregivers*. Champaign, IL: Research Press.

Rando, T. A. (1991). *How to go on living when someone you love dies*. New York: Bantam.

Reilly, T. P., Hasazi, J. E., & Bond, L. A. (1983). Children's conceptions of death and personal mortality. *Journal of Pediatric Psychology*, *8*, 21-31.

Robinson, R. A. (1977). The development of a concept of death in selected groups of Mexican-American and Anglo-American children. Doctoral dissertation, California School of Professional Psychology, San Diego. *Dissertation Abstracts International*, *38*, 4478B.

Sameroff, A., & Chandler, M. (1975). Reproductive risk and the continuum of caretaking casualty. In F. Horowitz, E. Hetherington, P. Scarr-Salapatek, & A. Siegal (Eds.), *Review of Child Development Research*, (Vol. 4, pp. 187-244). Chicago: University of Chicago Press.

Saravay, B. (1991). Short-term play therapy with two preschool brothers following sudden paternal death. In N. Webb (Ed.), *Play therapy with children in crisis: A casebook for practitioners* (pp. 177-201). New York: Guilford Press.

Scheeringa, M. S., Zeanah, C. H., Drell, M. J., & Larrieu, J. (1995). Two approaches to the diagnosis of post traumatic stress disorder in infants and early childhood. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34*, 191-200.

Schilder, P., & Wechsler, D. (1934). The attitude of children towards death. *Journal of Genetic Psychology*, *45*, 406-451.

Schonfeld, D. J., & Kappelman, M. (1990). The impact of school-based education on the young child's understanding of death. *Journal of Developmental and Behavioral Pediatrics*, *11*, 247-252.

Schonfeld, D. J., & Smilansky, S. (1989). A cross-cultural comparison of Israeli and American children's death concepts. *Death Studies*, *13*, 593-604.

Seide, J. H. (1983). The effect of experience with death on children's understanding of death. Doctoral dissertation, Boston College. *Dissertation Abstracts International*, *44*, 627B.

Shahinfar, A., & Fox, N. A. (1997). The effects of trauma on children: Conceptual and methodological issues. In D. Cicchetti & S. L. Toth (Eds.), *Rochester symposium on developmental psychopathology: Developmental perspectives on trauma, theory, research, and intervention* (Vol. 8, pp. 115-139). Rochester, NY: University of Rochester Press.

Shannon, M. P., Lonigan, C. J., Finch, A. J., & Taylor, C. M. (1994). Children exposed to disaster I: Epidemiology of post traumatic symptoms and profiles. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*, 80-93.

Shaw, J. A., Applegate, B. A., Tanner, S., & Perez, D. (1995). Psychological effects of hurricane Andrew on an elementary school population. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1185-1192.

Silverman, P. R., & Worden, J. W. (1992). Children's reactions in the early months after the death of a parent. *American Journal of Orthopsychiatry, 62*, 93-104.

Sisson, P. (1987). Children's conceptions of death: The influence of cognitive development and death related experience. Doctoral dissertation, University of Northern Colorado. *Dissertation Abstracts International, 48*, 2805B.

Speece, M. W., & Brent, S. B. (1984). Children's understanding of death: A review of three components of a death concept. *Child Development, 55*, 1671-1686.

Speece, M. W., & Brent, S. B. (1992). The acquisition of a mature understanding of three components of the concept of death. *Death Studies, 16*, 211-229.

Speece, C., & Brent, S. (1996). The development of children's understanding of death. In C. Corr & D. Corr (Eds.), *Handbook of childhood death and bereavement* (pp. 29-50). New York: Springer Publishing.

Steiner, G. L. (1965). *Children's concepts of life and death: A developmental study*. Doctoral dissertation, Columbia University. *Dissertation Abstracts International, 26*, 1164.

Swain, H. L. (1979). Childhood views of death. *Death Education, 2*, 341-358.

Terr, L. C. (1981). Forbidden games: Post-traumatic child's play. *Journal of the American Academy of Child & Adolescent Psychiatry, 20*, 741-760.

Terr, L. (1983). Chowchilla revisited: The effects of psychic trauma four years after a school bus kidnapping. *American Journal of Psychiatry, 140*, 1543-1550.

Terr, L. (1988). What happens to early memories of trauma? A study of twenty children under age five at the time of documented traumatic events. *Journal of American Academy of Child & Adolescent Psychiatry 27*, 96-104.

Thomas, R. M. (1992). *Comparing theories of child development* (3rd ed.). Belmont, CA: Wadsworth Publishing.

Toomey, B. G., & Christie, D. J. (1990). Social stressors in childhood: Poverty, discrimination, and other catastrophic events. In L. E. Arnold (Ed.), *Childhood stress* (pp. 423-456). New York: Wiley.

Udwin, O. (1993). Annotation: Children's reactions to traumatic events. *Journal of Clinical Psychology and Psychiatry, 34*, 115-127.

van Ijzendoorn, M., & Kroonenberg, P. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange situation. *Child Development, 59*, 147-156.

Walco, G. A. (1982). *Children's concepts of death: A cognitive training study* (ERIC Document Reproduction Service No. ED222282). Columbus: Ohio State University.

Walco, G. A. (1984). Fatally ill children's comprehension of death. Doctoral dissertation, Ohio State University. *Dissertation Abstracts International, 45*, 2706B.

Walsh, F. (1998). *Strengthening family resilience*. New York: Guilford Press.

Wass, H., Guenther, Z. C., & Towry, B. J. (1979). United States and Brazilian children's concepts of death. *Death Education, 3*, 41-55.

Wass, H., & Towry, B. J. (1980). Children's death concepts and ethnicity. *Death Education, 4*, 83-87.

Webb, N. (1993). *Helping bereaved children: A handbook for practitioners*. New York: Guilford Press.

Weber, J. A. (1981). Family dynamics and the child's concept of death. Doctoral dissertation, Oklahoma State University. *Dissertation Abstracts International*, 42, 2318A.

Weininger, O. (1979). Young children's concepts of dying and dead. *Psychological Reports*, 44, 395-407.

Weisenberg, M., Schwarzwald, J., Waysman, M., Solomon, Z., & Klingman, A. (1993). Coping of school age children in the seated room during a scud missile bombardment and post war stress reactions. *Journal of Consulting and Clinical Psychology*, 61, 462-467.

Wolfelt, A. (1983). *Helping children cope with grief*. Muncie, IN: Accelerated Development.

Worden, J. W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (2nd ed.). New York: Springer Publishing.

Worden, W. (1996). *Children and grief: When a parent dies*. New York: Guilford Press.

Young, M. A. (1998). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

17

危機

The Community Crisis Response Team: The National Organization for Victim Assistance Protocol[1]

Marlene A. Young, Ph.D.
National Organization for Victim Assistance

The National Organization for Victim Assistance (NOVA) fielded its first community crisis response team in 1986 when it sent seven crisis intervenors to Edmond, Oklahoma, after the post office massacre in which 14 people were killed. Since that time, NOVA has been involved in some 125 on-scene responses to community tragedies. The question is often raised today: how many of those responses involved school communities and students? The answer is unequivocal: all of them.

On January 4, 1987, a Conrail train collided head-on with an Amtrak train in Baltimore County, Maryland, killing 16 people and injuring hundreds of others. Neighbors, including teenagers, from surrounding areas rushed onto the train tracks to rescue people from the debris, and many passengers wandered away from the train and into the homes of community members. School children witnessed the destruction, death, and injuries. Many played out "train wreck" games on school playgrounds for weeks afterwards, much to the distress of teachers.

On May 14, 1988, after a Sunday church outing, a school bus traveling back to Radcliff, Kentucky, from Carrollton, Kentucky, was hit head on by a car driven by a drunk driver. Twenty-seven individuals were killed, including 24 children. Children who survived suffered smoke inhalation or were badly burned. NOVA's team worked with the schools and community of Radcliff to address the aftermath during summer vacation; special emphasis was placed on preparing for the opening of school the following fall.

In September 1991, just before schools opened for the year, Hurricane Andrew swept through south Dade County, Florida, destroying 85,000 homes and nine school buildings. At the time it was the most expensive natural disaster in the history of the United States and disrupted the lives of hundreds of thousands of people.

On April 19, 1995, America awoke with shock to the news of the most devastating terrorist attack in U.S. history, the bombing of the Alfred P. Murrah building in Oklahoma City, Oklahoma, which killed 168 people and injured hundreds more. This crime and its aftermath left a wake of trauma, particularly among the young people of the community. Nineteen children were killed. The injury or death of a loved one directly victimized some 600 children and adolescents. Almost everyone in Oklahoma City felt the reverberations of the bomb in their homes or schools. NOVA deployed 27 crisis intervenors to assist in the Oklahoma City school system. NOVA also worked with Athletes Helping Kids to organize and hold a grief intervention clinic with National Football League players to help children address their grief reactions. Whatever the source of the community crisis, it always has a disturbing impact on the children of that community.

From early 1997 to early 2001, murders by students perpetrated on other students and school personnel rocked the nation. The names of the communities afflicted by such violence now resonate in public memory, for instance Bethel, Alaska; Pearl, Mississippi; West Paducah, Kentucky; Jonesboro, Arkansas; Edinboro, Pennsylvania; Fayetteville, Tennessee; Springfield, Oregon; Littleton, Colorado; Conyers, Georgia; Fort Gibson, Oklahoma; and Santee, California. Their school systems—indeed, all the nation's school systems—will never be the same. NOVA crisis teams and volunteers responded to six of these catastrophes.

In addition to such major disasters, NOVA also responds to individual tragedies such as suicide, murder, sexual assault, or car accidents, which can also cause crisis throughout school districts. For some schools, these events are not everyday occurrences, but for others, they have become almost routine. Most schools have plans for responding to natural disasters or structural emergencies through evacuation, emergency drills, and by providing physical aid and assistance. Most do not have plans for coordinating emotional aftercare for victims, witnesses, and survivors who have been traumatized, or for those who are trying to cope with the crisis but could use additional help.

Key Lessons in School Crisis Response

NOVA's experience has resulted in key lessons in crisis response. These lessons include the following:

1. Most communities and individuals live their lives in denial of the possibility that tragedy can happen to them and particularly to their children and their schools. As a school district crisis response team leader stated after the Thurston High School shooting in Springfield, Oregon, "Our sense of safety and security was shattered along with our innocence, and no longer could *we* say, 'It can't happen here." (NOVA CRT Report, June, 1998).

2. Schools are often well prepared to cope with natural or structural disasters through practical emergency plans that include evacuation procedures, shel-

ters, lock-downs, pre-emergency drills, and designated emergency assignments for personnel. They are less well prepared to cope with events that are precipitated by violence and to address the emotional impact of catastrophes and their aftermath on students and personnel.

3. When planning for crisis responses, school leaders often focus only on tragedies that might happen on school grounds or within the school community, as opposed to those that occur in the community at large but affect the school community. Similarly, communities with crisis intervention teams may assume that schools will "take care of their own." This mutual exclusivity often impedes effective psychological first aid and long-term interventions.

4. Crisis situations interrupt a school's primary mission: the education of children. They often reduce a school's average daily attendance. (NOVA's observations suggest that this has been particularly true after the various school shootings. In the aftermath of the shooting at Columbine High School, attendance throughout the nation fell as parents kept their children home or as children refused to go to school because of their fears.) Crises disrupt school routines and schedules. They also cause students to be inattentive or have difficulty concentrating.

5. Immediate crisis response efforts should be viewed in terms of a continuum of response. Ideally, plans, policies, protocols, and awareness of what could or might happen should be established and promoted throughout the school and community as part of preparation and prevention activities. "Trauma inoculation" suggests that understanding stress and trauma helps individuals to cope when crises occur. This term has been coined by many in the victim's movement to summarize the results of research in responding to terrorist victimization (e.g., Eitinger, 1964; Eitinger & Strom, 1973; Lindy, 1993; Lindy & Wilson, 1994; Ochberg & Soskis, 1982). Immediate crisis response should focus on planning for the future (short and long term), mutual support activities for caregivers, crisis intervention for individuals and groups, and training and education for coping with the experience. Immediate crisis response should not be viewed as a one-time, self-sufficient "fix." It is only one part, albeit an important one, of an ongoing strategy of responding to an event. Long-term crisis response includes practical planning for addressing possible secondary stressors such as memorials, criminal or civil justice issues, media coverage, and the like; supportive counseling for adults and children who are coping but could be coping better; retrospective or repetitive crisis intervention for adults or children who may need additional assistance in the future but are still functioning well; and trauma therapy for those who may remain symptomatic.

6. Multidisciplinary teams of responders are more effective than others because they provide a school system and a community with an enhanced ability to access, coordinate, and integrate all populations that regularly interact in times

of crisis, such as health and mental health professionals, law enforcement, schools, religious institutions, businesses, and employers.

7. Many school districts that have created a crisis response team have chosen to make it a community resource, not just for schools. Three reasons support that decision. First, the districts chose to look outside their own personnel for team membership, both because of inadequate numbers of people available in-house and because they subscribed to the multidisciplinary model—the buyoff for that was to make the team available to all community groups. Second, they appreciated that school-centered disasters, while horrible, are blessedly quite rare. And third, they acknowledged that, to work most effectively, their crisis response teams must practice the skills they have been taught, which argues for their deployment whenever appropriate.

The Nature of Crisis

This chapter focuses on those lessons by integrating findings from a review of the literature and providing schools and communities with a step-by-step outline of a response plan. To set the stage for that discussion, it may be helpful to review the nature of crisis and the goals of the proposed response to it.

A crisis situation may be described as an event that is extraordinary or outside of the usual day-to-day activities of a community or individual. In generic terms, a crisis may be experienced as positive or negative, and it may be short or long term in duration (Young, 1998). This chapter focuses on crises that create harm and, in most cases, are of relatively short duration. Harm may involve physical, financial, emotional, or social injury. A crisis reaction occurs when individuals respond to the situation with feelings of powerlessness or helplessness. They internalize the effects of the harm done. Such reactions are physical, emotional, and cognitive. People may be able to adapt to these reactions and the situation if they have strong coping capacities. Such capacities include physical health and abilities, mental and emotional resources, spiritual beliefs and connections, social support systems, and previous relevant education and experience. If their coping capacities are insufficient, they will likely experience long-term effects in response to the event. They may become traumatized. In providing immediate crisis response to schools and communities, the goal is to help them to deal with the immediate effects of the crisis, to promote prevention or mitigation of serious trauma reactions, and to promote the prevention of future crises.

Review of the Current Literature

Perhaps the two most critical issues to examine regarding the efficacy of school crisis response are (a) the information available concerning the value of individual and group crisis intervention among school and community populations and (b) the strategies used by school crisis teams.

Implications of Traumatic Events

To understand the potential value of crisis response work, it is important to know information about the implications of traumatic events. Most of the original work concerning crisis intervention stemmed from the studies done during World War I among soldiers on the battlefield and those returning home (Kardiner, 1941). In 1917, T.W. Salmon suggested the PIES model for intervention (Parolotz, 1917). It featured concepts of proximity (geographic), immediacy (time), expectancy (hope for success), and simplicity (telling the story). World War I and its consequences for soldiers became the precursor both for the study of trauma and for crisis intervention techniques. Lindeman's article (1994) describing the impact of the Coconut Grove nightclub fire is considered seminal in the understanding of trauma and its variables. However, the publication of the formal diagnostic criteria for posttraumatic stress disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980) was a breakthrough for developing data and understanding traumatic stress. Over the past 20 years a large body of literature has developed (Danieli, Rodley, & Weisaeth, 1996; Herman, 1992; Terr, 1990; 1994; van der Kolk, 1987; van der Kolk, McFarlane, & Weisaeth, 1996). Systematic studies have also been conducted concerning the rate of exposure to traumatic events and the eventual impact (e.g., Figley, 1985; Jones, 1985; Raphael, 1983; 1986; Ursano, McCaughey, & Fullerton, 1994).

It has been estimated that 75% of the general population in the United States will be exposed to stressors that meet the criteria for precipitating PTSD as defined in the fourth edition of the DSM (American Psychiatric Association, 1994) in their lifetime (Green, 1993). It has also been suggested that 75% of any group exposed to a catastrophic event will be initially dazed, stunned, and in shock. On a positive note, the majority of victims of traumatic life events are able to successfully cope with the trauma. A substantial minority, however, may go on to suffer from subsequent symptoms found in PTSD (see Chapter 18, Estimating the Appropriate Crisis Response, for further discussion of this issue).

Children's Responses to Traumatic Events

The studies of children's responses to traumatic events have been less quantitative, but they have helped to understand reactions of children to trauma (see Bell & Jenkins, 1993; Osofsky, 1997; Perry, 1994; Pfeffer, 1997; Pynoos & Nader, 1993; Pynoos, Steinberg, & Goenjian, 1996). The severity of those responses seems to be predicated on the following (summarized from Young, 1998): (a) the reactions of children tend to mirror adults around them and, hence, if adults are perceived to be in crisis, children will be more sensitive to the crisis situation; (b) degree and duration of exposure to threat of loss of life, witnessing gruesome scenes, physical injury, or loss will increase risk of trauma; (c) significant (as perceived by the child) property loss and dislocation or disruption of a child's environment will increase risk; (d) symptoms depend on gender and age; and (e) for many, exposure to a sudden, short-term, extraordinary event will cause immediate reactions that tend to decrease or go into remission within a few years unless there are additional crisis stressors. (For additional information on this topic, refer to Chapter 19, Identifying Individuals at Risk for Psychological Trauma.)

The generality of crisis reactions and significant level of long-term trauma reactions among the general population have resulted in an increased interest in how to respond to crisis, as well as prevention and intervention techniques. It should be understood that complete and total "prevention of crisis situations" is an untenable goal—crises will arise. A focus should therefore be on the prevention of disabling reactions and long-term consequences.

Research on the Importance of Crisis Intervention

Research on the value of crisis intervention in groups or for individuals is sketchy at best. There is a general consensus among responders that victims and survivors appreciate crisis intervenors. (NOVA maintains case files from its interventions from 1986 through 2000. These files include reports from responders and victims on the efficacy of the intervention that indicate this common consensus.) There is ample anecdotal evidence from individuals and communities that the opportunity to talk about what happened in a traumatic event and to tell the story of the event is perceived as useful. Research tends to confirm that those exposed to a catastrophe perceive a need for intervention and believe in its benefit (Feuer, 1994; McCammon & Allison, 1995; Robinson & Mitchell, 1993).

What is less clear is whether immediate crisis intervention has any long-lasting good. Indeed, some studies would seem to be highly critical of the group interventions (Bisson & Deahl, 1994; Kenardy et al., 1996; Meichenbaum, 1994). The general problem with the criticisms of group crisis intervention, however, centers on their misunderstanding of its purpose and implementation. Meichenbaum (1994), for instance, indicates that such intervention is unlikely "to provide effective treatment for complex, ongoing, or persistent problems that are the result of the disaster itself, predisaster vulnerabilities, or the variety of social conditions that surround it" (p. 517). Bisson and Deahl (1994) emphasize that "individuals receiving PD (psychological debriefing) are not immune from later psychological sequelae. Therefore, if PD is employed following traumatic events, formal follow-up to identify individuals who do go on to develop serious psychological sequelae is vital" (p. 719). They further suggest that, for victims who enjoy solid social support in their lives, such intervention may be unnecessary.

It should be emphasized that crisis intervention as used in NOVA's protocols is not expected to obviate the need for additional follow-up for some individuals. It is conceived of as an initial step that will help some more quickly assimilate what has happened, others to begin the process of organizing their thoughts and reactions to the traumatic event and, in some cases, help intervenors or participants identify the need for additional follow-up interventions. NOVA places a strong emphasis on encouraging communities to provide opportunities for ongoing services and rebuilding natural coping capacities.

Table 1

NOVA's Basic Community Crisis Response Training Curriculum

Day One
- Orientation on crisis response teams
- Dimensions of emotions
- Processing of trauma through memory
- Acute stress factors
- Long-term stress reactions

Day Two
- Death and dying
- Crisis intervention and death notification
- The continuum of age: children and elderly
- Cultural perspectives

Day Three
- Posttrauma counseling
- Spiritual dimensions in crisis
- Group crisis intervention skills
- Coordinating a community crisis response team

Day Four
- Simulated group crisis intervention
- Case study presentations

Day Five
- Practice group crisis intervention
- Stress reactions of caregivers

Graduation

A number of studies of longer-term posttraumatic interventions with children and adolescents have illustrated their success in reducing the incidence of posttraumatic symptomology (Galante & Foa, 1986; Gillis, 1991; Stallard & Law, 1993; Stewart et al., 1992; Yule, 1992). NOVA's model for school and community crisis response is a comprehensive approach in that it involves pre-crisis planning, immediate assistance with in-crisis planning, training and education, individual and group crisis intervention, and long-term follow-up interventions that address both practical and psychological ramifications from the traumatic event (see Table 1).

NOVA's Model for School Crisis Response

NOVA's experience has led to the development of a model for school crisis response. This includes a pre-crisis plan and an in-crisis protocol, as outlined on page 340.

The Pre-Crisis Plan

1. *Establish an interagency task force to deal with school crises.* An interagency task force or coordinating body should be established that will be responsible for implementing the designated action steps in the plan. A hierarchy of authority and responsibility should be outlined. Important agencies to include in the task force or coordinating body are: (a) law enforcement, (b) fire department, (c) coroner's office, (d) prosecutor's office, (e) community or other mental health agencies, (f) clergy, (g) hospitals, (h) state or local chapters of NOVA, and (i) state or local victim assistance or compensation programs.

The school may be the lead agency in planning for school disasters, but these other agencies are important resources and often will be the focus of liaison efforts during a crisis itself. It can be useful to include a representative of local media since the school will be the focus of media attention in a crisis. That representative can not only help the school develop a reasonable media plan, but also facilitate the implementation of such a plan when outside media converge in the area.

2. *Establish a school crisis response team.* The school superintendent or principal should lead the team. The crisis team leader will supervise all planning for crises and long-term responses to crises. In most cases the leader will have full authority to "govern" the crisis. However, in many cases other issues occurring simultaneously with the immediate implementation of a crisis plan will distract the crisis team leader. Hence, the crisis response team leader should designate a *crisis manager* to be the decision maker when a crisis occurs. The crisis manager should have back-up personnel trained and available to substitute if he or she cannot assume the responsibility. The crisis manager should be directly assisted by four people: (a) a *logistics coordinator*, to handle all practical issues that arise, such as implementing evacuation procedures, establishing a central location for converging parents and community members who are seeking information about the event, and accounting for all students and school personnel; (b) a *coordinator for psychological response*, most likely a school psychologist or counselor; (c) a *development coordinator* whose job it is to identify and access funding and other resources that may be available to assist with the economic needs of the school; and (d) a *media coordinator*, to deal with media inquiries and manage media logistics (this person should not be the media spokesperson). The team should also include representatives of each occupational title within the school community such as teachers, custodial staff, cafeteria staff, clerical personnel, and transportation staff.

A support team of crisis intervenors who are available 24 hours a day to respond to a tragedy should be organized under the direction of the coordinator for psychological response. The team should involve enough people such that 8 to 10 members can be ready to serve at any time. This means involving local mental health or victim assistance professionals who are prepared to respond to traumatic events. Such intervenors should receive a minimum of 40 hours of training in communitywide crisis response (see Table 1, on page 339), participate in regular preparedness exercises, and be familiar with ongoing changes in community demographics, dynamics, and resources. Not all members of the team will be needed in any one crisis but they all need to be prepared.

3. ***Develop a directory of local, state, and national resources.*** A directory should be organized and maintained with a current listing of key local, state, and national resources that can be used for assistance during a mass tragedy. It should be prioritized based on what resources should be contacted within the first 24 hours, within the first week, and within the first year after the event. Each listing should identify key contact people, telephone and facsimile numbers, and the types of help that can be provided. If possible, schools should develop a database with such information so that it can be routinely updated.

4. ***Establish a permanent emergency fund.*** A permanent revolving emergency fund can assist victims and survivors who have suffered physical or financial losses or who may need mental health counseling as a result of a trauma. Establishing a permanent fund will allow schools to ensure that all legal, administrative, and banking requirements are met prior to a mass tragedy and that the community can immediately solicit and process donations or contributions. Schools should consider whether this fund should be established in conjunction with a communitywide disaster fund so that they can access such funds when a tragedy occurs outside of a school campus and affects the school or when a tragedy occurs on a school campus but does not directly affect the whole community. Guidelines for application for emergency funds and methods for disbursement of funds should also be developed to facilitate response to victim needs. One of the most divisive issues following a major disaster in a school or community is how funds are used.

5. ***Establish guidelines for identifying high-risk populations.*** As a part of preparedness, schools should give thought to what groups within their community will be most in need of immediate services as well as methods for providing such services as soon as possible. Such populations include teachers, parents, students, specific cultural groups, specific religious populations, and crisis responders themselves. If certain cultural groups within the community are non-English-speaking, plans should be made to ensure that emergency translators can be available during a tragedy.

6. ***Designate response facilities.*** Specific facilities should be identified that can be used for crisis response coordination, group meetings, training sessions, or special services while responding. Such facilities might include schools, churches, community buildings, training centers, and hotel space. Schools may be used for these kinds of meetings, but sometimes a disaster will destroy a school or make it inappropriate for meetings to take place there, so alternative locations should be identified. Agreements with owners of such facilities to allow their use during emergencies should be in writing.

7. ***Designate priority lodgings or shelters.*** Current emergency plans for many jurisdictions have designations for shelters in case of natural disasters; however, such plans may not include predesignation of alternative sites for schools or workplaces should there be a criminal attack that would necessitate it. It is also important to pro-

vide lodging for crisis intervenors or rescue workers who may be asked to travel to the community to assist local care providers. Because of to the phenomenon of convergence (i.e., many individuals arriving on site), it is important for communities to think through how such alternative space will be provided.

8. ***Establish a communication system.*** It is essential to identify a communication headquarters and equipment for use during a tragedy prior to an event. Constant communication between crisis team members is a top priority as they come in contact with individuals and groups that may need assistance. Telephone communication may be difficult without a central coordinating facility; cellular communication is often subject to malfunction due to the excessive demands on service. It can be helpful to designate an emergency telephone number that victims and survivors can call for information and assistance, to establish telecommunication linkages through the Internet or the World Wide Web, and to consider the possibility of short-wave radio as a backup if all other equipment were to fail.

A communication system also involves identifying key members of the crisis team to work with specific populations. The parent/family liaison suggested by Poland and McCormick (1999) is one example of a part of that system. Depending on the nature and size of the tragedy as well as the community itself, other liaisons may be needed as well, such as a liaison with a specific cultural group or with the teachers' union.

9. ***Design a system of response identification.*** Identification materials for all potential responders to the site of a catastrophe should be designed so that only those designated in the plan are allowed at the site of the tragedy, shelters, or meeting places to work with victims and survivors. It has been far too common in the communities where school shootings have occurred that unwanted intruders have disrupted the efforts to regain control over the event. Guidelines for authenticating credentials at the site should be developed so that clearance of personnel is expeditious and efficient.

10. ***Develop an information dissemination system.*** A public information team should be established and trained to help manage media coverage and disseminate information on the emotional aftermath of the tragedy. The media coordinator should lead this team. It is useful if the team could be made up of public information representatives from each of the key decision makers that might be called upon to make statements in a tragedy. The school superintendent may be the school district's media spokesperson and the public information/relations representative may well be the media coordinator, but the media will interview other community decision makers as well. For successful control, it is critical to have everyone who is interacting with the media to be operating under the same guidelines and understanding of the facts. Representatives from other key decision makers might include a mayor's office, county commission office, law enforcement agencies, prosecutor's office, and key state officials.

11. ***Develop a plan for dealing with death-related issues***. Crisis response teams should learn about mortuary procedures and funeral home practices in the community so

that team members can explain what options are available to family members who have experienced the sudden death of a loved one. Talking to local coroners and law enforcement officials about procedures for body identification and requirements for autopsies is recommended. Particularly in small communities, the interagency task force should designate alternative morgue facilities should a tragedy result in multiple deaths.

It is also important to determine how the school population will be notified about a death. For individual deaths, death notification should follow standard procedures of first notifying the individual(s) or class(es) who are closest to the deceased. Such notification should be done in person if the death occurs during a school day or week. If the death occurs on a weekend, a telephone tree using trained counselors or teachers should be established and used as soon as possible.

When there are multiple deaths during a school day, a plan should be developed that assigns all school personnel and students to pre-identified locations during emergencies. All personnel and students should be alerted to report to these locations for updates on the tragedy unless the school is under siege. If the school itself is threatened, the plan should address where the school population will assemble in the community for updates and information. Crisis response team members should be dispatched to their various population groups to provide necessary death or injury notification as it becomes available.

A schoolwide plan for memorialization of students or school personnel who die should also be developed. This plan should approach memorialization in two parts: memorial services immediately after an event and permanent memorials.

It is important to treat memorial services in a similar and consistent manner. A school should decide whether it will allow memorials on school time or not. No matter which decision is made, it should be consistent no matter what the method of death. One of the needs for being consistent arises because of the concern of doing memorial services after suicides. NOVA suggests that it is possible to hold such services to remember the deceased, but that the ceremony should be planned to emphasize suicide prevention. Suicide "contagion" among students can be mitigated with accompanying discussion and interventions. It is important to acknowledge the death of school community members and provide opportunities for those affected to be allowed to grieve. (See Chapter 27, School Suicide Postvention, for further discussion of this issue.)

A similar problem arises when a student dies or is arrested after having been the perpetrator of assaultive violence. There is often an undercurrent of sympathy for the offender, which can cause divisiveness in the school community. If it goes unacknowledged, such divisiveness can breed further violence. NOVA is in the process of developing guidelines for intervention in these situations on the basis of crisis intervention techniques and restorative justice protocols.

The problems presented by inconsistent approaches to memorial services were illustrated in a school whose administrator called NOVA toward the end of a school year. A tenth-grade student had committed suicide on Halloween night. He had been relatively popular and had numerous friends who were devastated by his death. The school had a ban on memorials after suicide. There was no public acknowledgment of his death at the school. A basketball star who was a senior at the school had been shot and killed in February. The school held a schoolwide memorial service, and counselors were available to all students upon request. While most students were supportive of the memorial service, many tenth-graders were extremely upset that their friend had not been noticed. In April, another tenth-grader died. She was killed in a car crash. She was not popular but the school held a schoolwide memorial service to respect her life. Some tenth-graders boycotted this memorial because of its unfairness to the student who committed suicide in October.

The administrator who called NOVA asked how to defuse this aggregation of concern. NOVA suggested holding schoolwide discussions with students and school personnel on the problems that had occurred during the year over memorials and to decide on a consistent plan for the future. One of the aspects of that plan was to hold a retrospective school assembly to note all of the students who had died during the year and to end the assembly on an inspirational look at the future. Assemblies should be designed such that they do not convey that death is a way to gain attention.

Another way to avoid the stresses of school memorials is to have a policy that states that the school will not officially hold memorials for students who have died. If family or community memorials are held during school time, schools may allow student attendance.

Permanent memorials, such as plaques, tree plantings, and annual events in honor of the deceased, should be treated differently but consistently. No permanent memorials should be erected or established for those who die by suicide or due to their own criminal misconduct (which includes driving while under the influence of drugs or alcohol, drug overdoses, drug dealing, reckless driving, gang membership, or the reckless endangerment of others with deadly weapons). If funds are donated to the school in memory of such a person, those funds should be integrated with existing funds for positive purposes. Permanent memorials might be considered for extraordinary events such as the recent school shootings or a major flood, tornado, or earthquake that killed a number of students. They mark a time in the life of the school and community that will forever be a demarcation point for life in the future. For school tragedies that are more confined in their impact it is often preferable to focus on what Scott Poland calls a "consumable" gesture such as a scholarship (Poland & McCormick, 1999).

12. Plan for medical care. This might be considered the first point of developing a crisis response plan; however, it is included in this model as a final point to planning because most schools and communities have established procedures for responding to physical emergency needs. Schools may have a school nurse or someone trained in emergency medical care to administer first aid, triage the injured, and keep records on the identities of the patients and what happens to them. Hospitals and medical emergency response care is available in most urban and suburban jurisdictions. However, immediate care may not be available in semirural and rural areas. Even in schools and communities where hospital and emergency staff are available, they may not be prepared to cope with the sheer numbers of injured people that a crisis involving mass violence can generate. It is essential to train a team of school personnel who can help nurses and others to administer first aid. It is also essential to identify priority care facilities that are easily accessible from anywhere in the jurisdiction. Staff at such care facilities needs special training in dealing with response to mass injuries.

The In-Crisis Protocol

1. ***Assess the crisis and organize the response plan.*** Assessment must be done immediately. Some of the questions to ask include: How many people are injured or dead? How many have witnessed the event? How many are family, friends, teachers, or colleagues of the direct victim(s)? How much of the school property is destroyed, and how many individuals use that property on a regular basis? Was the individual(s) who was a direct victim(s) of particular importance to the school or community? Was the property destroyed of particular significance? How much has school routine been disrupted or will it be disrupted? Are there unique issues surrounding the event that will cause unusual problems? For example, a school shooting will involve law enforcement—perhaps closing the school as a crime scene for some time—with the possibility of an arrest and trial. This will involve repercussions for the school community. A school bus-train collision may involve civil litigation because of the malfunction of a train-crossing barrier. A murder of a gay student may present issues surrounding hate crimes or homophobia.

The purpose of the assessment is to determine the nature and scope of the tragedy and to decide whether local crisis response teams can cope with the effects or whether there is a need for state, regional, or national resources. While the assessment should be done quickly, it is important to do it realistically. One suicide, homicide, drunk driving crash, or swimming accident may be handled well by an in-house school crisis team. As the numbers of those dead, wounded, or directly affected by the tragedy mount, the need for people outside a specific school community to intervene also increases. Often the event directly affects school or community caregivers. They may have known one of the victims or witnessed the traumatic incident. They also may need care. Whenever the initial assessment causes the crisis manager or team members to question whether they can successfully intervene, they should ask for help from other school districts, regional or state offices, or national agencies and organizations. As hours pass, they may reassess what has happened and determine that no outside help is needed. In such a case, it is easy to tell outsiders not to arrive, but the request for help ensures that, if outsiders are needed, they will be there.

2. ***Confirm who is in charge.*** The pre-crisis planning effort should have designated a crisis manager, but if she or he is incapable of working on this crisis, confirm the line of succession. The crisis manager should meet as soon as possible with his or her four coordinators to identify who among the crisis team members will be used immediately and who will be used on ensuing days. The crisis team members should be notified immediately and be given all information available.

3. ***Hold a crisis management meeting.*** The crisis manager and coordinators should discuss the best approach to handling the crisis to address the psychological ramifications for the school and community. Needless to say, discussion will also address the need to continue the primary function of the school—education.

4. ***Develop a crisis portfolio.*** The media coordinator should immediately be assigned the duty of developing a crisis portfolio. It should include five things: (a) a crisis fact sheet that summarizes what has happened, who has been injured or killed, and critical witnesses; (b) unique issues of the catastrophe; (c) a summary of the school crisis plan; (d) short synopses of the background of crisis team members; and (e) an overview of predictable crisis reactions and long-term stress reactions.

This portfolio should immediately be distributed to crisis response team members. The first two elements, the crisis fact sheet and the fact sheet on unique issues of the catastrophe, will serve as briefing papers. The last three elements will help team members focus on what they have learned in training and give them confidence in working together. In small school districts it may not be as important to include the paper on crisis team members' backgrounds because they know each other. In large school districts, this is an essential item because, while team members may have trained together, they may not have learned enough about each other to fully trust everyone's capability. It is useful for the media coordinator to do this job since the crisis portfolio may be used as the basis for news releases during the crisis and its aftermath as well as for response to news questions.

5. ***Address immediate issues.*** The crisis management team needs to address the following immediate issues: (a) identification of students and staff who may be affected, (b) possible school closure, (c) possible adjustment of class and homeroom schedules, (d) type and content of announcements to be made, (e) who will make announcements, (f) when and where individual and group crisis intervention will be available, (g) when and where refresher training for crisis intervenors at the school and in the community will be held, and (h) when and where family or community meetings will be held.

6. ***Hold a press conference as soon as possible.*** The media coordinator should work with the press to make any decisions that are appropriate to communicate to the public. This may be accomplished through a press conference as soon as the assessment and initial decision-making meeting has been accomplished. The sooner a press conference is held, the sooner the school can begin to manage the media as opposed to simply reacting to media questions.

7. ***Plan for school clean-up, memorial services, and alterations in security, if necessary.*** The logistics coordinator should take the lead in organizing and implementing any clean-up after the disaster. If the tragedy has involved a crime on school grounds, the custodial staff may be responsible for cleaning up blood or bodily fluids and straightening up chairs or desks. In some communities, this function may be contracted to a local clean-up service. If the tragedy involved a natural disaster such as a flood, earthquake, or hurricane, building contractors may need to be contacted immediately.

NOVA's experiences have suggested that it is important not to eradicate all signs of the crisis. Many members of the school and community may need to see the site to absorb what happened. It is also important to leave personal items such as book bags or contents of desks as much as possible in the way they were found. This will maintain a sense of continuation from the time the event happened until the time that the person or the family reclaims them.

While the crisis management team will work together to plan memorial services, it is the logistics coordinator's job to identify appropriate areas in the school or community for those services and to identify safe entrances and exits. The logistics coordinator will also pay attention to the number of people expected to attend and arrange for adequate seating, appropriate refreshments (if any), and appropriate signs to direct those who are unfamiliar with the memorial location.

In cases of crime, the logistics coordinator should take the lead in recommending additional or alternative security arrangements that should be implemented. These recommendations should be made in conjunction with local law enforcement and may involve short- or long-term changes in school schedules, the physical environment, or school routines.

8. ***Arrange for crisis intervention.*** The coordinator of psychological services should designate members of the crisis response team to facilitate group crisis intervention with high-risk populations. These sessions might address students, teachers, custodial staff, support staff, or management staff. Initially, group sessions should be as homogeneous as possible so that those who have encountered similar experiences have a chance to receive peer validations. Over the first several weeks such group sessions may be broadened so that they become more heterogeneous, so that people with different experiences can expand their understanding of what happened. In addition, those at highest risk of psychological trauma should be seen individually by a mental health professional.

Based on NOVA's experience, it is recommended that children who have experienced a catastrophic event should have an opportunity to talk about it without their parents present. The parents of the same children should also have a chance to express their feelings without their children present. During such parent sessions it is also important to point out that adult reactions are very important in determining how children view the crisis event. During the next day or few days, the children and parents can be brought together in groups to explain to each other their reactions. The initial separation of children and parents is often difficult to accomplish because crisis causes many to experience fear of separation, abandonment, and death. The reason for trying to organize separate groups is that the developmental issues affecting children in trauma are significantly different from the issues affecting adults. In NOVA's experience, parents sometimes inadvertently dominate mixed sessions unless they are given alternative forums for the expression of their reactions. In addition, children may mask their reactions to compensate for the fears of their parents.

These group crisis intervention sessions focus on providing a safe environment for individuals to tell their stories about what happened to them. In the NOVA protocol for group crisis intervention, the procedure emphasizes the two critical organizing factors in the brain's processing of trauma: the context or the sensory inputs at the time of the experience and the chronology of the traumatic event and its aftermath (Young, 1998). The sessions also provide an opportunity for victims and survivors to receive validation that their experiences have been real and are understandable both from the facilitator and their peers. Finally, the sessions emphasize the integration of the tragic experience into each individual's and the community's life story. The past event is examined, the experiences that have been primary in the aftermath are expressed, and what can be prepared for in the future is explored. It is absolutely critical to focus on hope and the future for the individual and the community in order to combat potential depression and despair.

The coordinator of psychological services should also be responsible for designating members of the crisis response team to provide death notification to significant others when needed. The next of kin of anyone who dies will normally receive notification from law enforcement authorities, doctors, or the medical examiner's office. In a school population, however, many individuals might be particularly close to another person who is not their next of kin. The coordinator of psychological services will try to identify those who are most at risk for traumatic grief and arrange for specific crisis response team members to deliver that death notification in person.

The coordinator of psychological services should arrange the family or community meeting that may be held to discuss the tragedy. This meeting should be both informational and a process of crisis intervention. The informational part of the meeting should include a distribution of appropriate parts of the crisis portfolio, updates on the current status of the tragedy by the appropriate public official (e.g., school superintendent, mayor, prosecuting attorney, law enforcement chief, or sheriff), and counseling or financial referrals. The informational portion of the meeting should be held first. Following that, the meeting should become a group crisis intervention session. Additional mental health professionals may also be on site to provide support and assistance following the meeting. The school administrator should issue a letter of invitation to parents or community members to attend this meeting and designate the coordinator of psychological services as the facilitator of the session.

All faculty involved in a school tragedy should be mandated to meet with the coordinator of psychological services as soon as possible after a crisis. This meeting should be held before any student meetings and before school opens the next day if a crisis occurred during the previous day or the night before. The faculty meeting should focus initially on the needs of the faculty—their fears, anger, confusion, or grief over what has occurred. Next, the meeting should go over practical issues such as the plan for the day and week, including the bell schedule, policies regarding homework or testing that had been scheduled, and when memorials or funerals might interrupt ordinary routine. Finally, the faculty should be given tips on how they might answer questions from students, what they might expect in terms of emotional reactions, and warning signs that may help them spot and refer children who are experiencing crisis or traumatic reactions.

9. *Establish regular communications between crisis response team members.* The crisis response team members who are meeting with various groups of the school and community populations will be learning of new issues and concerns rapidly and regularly. They need to be in touch with each other. Several meetings a day are encouraged among crisis responders but, when that is not possible, it is important to ensure that at least one member of the crisis management team is designated and accessible to receive "reports in from the field." Often that person is the coordinator of psychological services but it may also be the crisis manager.

10. *Establish a rumor control hotline.* Crisis situations often spawn rampant and misleading rumors. If the crisis has affected the whole community, a rumor control hotline that is available 24 hours a day may be useful to help people get accurate information. With modern technology, some schools are turning to the Internet to post updated information on crises that affect them. Within schools, some institutions have established rumor control rooms that are staffed by crisis response team members who are kept abreast of the most recent information. Whatever system is employed, it is clear that reducing incorrect rumors reduces the eventual impact of the crisis.

11. *Hold daily intervention sessions with the crisis response team members.* Over the past decade much research has been done on the effects of vicarious trauma or compassion fatigue (Figley, 1995). Team members who have seen the site of a tragedy that may be littered still with massive property destruction or human remains and blood are undoubtedly affected by their impressions. Team members who listen to the harrowing stories of people who have barely survived death or seen a close friend die nearby are often similarly affected. They need to have a chance to process their own reactions to the crisis and to listen to others' experience as an anchor to reality. At the same time, team members need time to assess what they have accomplished each day, what has gone well, and what might be improved on in the following day. This type of logistical assessment can help keep the entire team on track.

12. *Keep track of news reports.* The media coordinator should designate someone to watch and listen to all media reports. It is not unusual for the media to report on things that never happened or to become intrusive with certain victims. Schools can keep the media off their immediate grounds, but they have little control over the media's efforts to contact students or school personnel at their homes. Many times a media report can exacerbate a traumatic situation or turn a relatively small crisis into a sensational event. If the media coordinator is on top of these issues, she or he can respond immediately with press releases or press conferences as appropriate.

13. ***Begin long range planning.*** As soon as the immediate crisis of the first 24 to 48 hours of a situation is over, crisis team members should meet with the school crisis response coordinator to plan for the next few weeks, months, and years. A major tragedy will affect a school community for its life. The focus over the next few weeks may be on memorials or continuing crisis intervention. The focus over the next few months may be on how to address holidays or significant school events such as homecomings, proms, or graduations. The focus over the next few years will be on such things as "remembrance dates," recognition of deceased students or heroes in yearbooks, addressing the trauma in terms of the developmental stages of children as they grow from elementary school to high school, and the like.

Practical issues will arise. How will the school respond to teachers who are frightened to return to school? Is there a plan for early retirement or leaves of absences that will allow teachers to change their lives to accommodate the tragedy? What opportunities do students have for transferring to other schools without financial hardship? How will the school deal with students whose grades begin to fall as a result of the trauma? What long-term changes will be made in safety and security measures at the school? How will the school respond to the media throughout the year and ensuing years when the media brings the tragedy back to public attention? How will the school respond when no one remembers the school's tragedy outside of the local community? Such issues need to be addressed by the whole school community in ways that do not demean or stigmatize any one individual. The sooner such issues are raised, the more conscientiously they can be explored.

Conclusion

Every school should establish an internal crisis management plan and ensure that the members of its crisis team are trained, practiced, and ready for crisis. At times schools will be exposed to major crises that have sensational and national ramifications, such as those precipitated by recent, high-visibility school shootings, but more typically, crises will be relatively confined to one school or one community. The potential widespread nature of crisis situations in schools is illustrated in the Hopewell Area School District in Aliquippa, Pennsylvania, which has experienced four to eight traumas a year involving death. The crash of US Airways Flight 427 (in which all 132 passengers and crew members were killed) occurred in the district in 1994. This catastrophe affected the district and community and had an impact on both national and international levels. In addition, among the traumatic events affecting the Hopewell Area School District were three parent/guardian suicides occurring within less than 36 hours, lightning striking and killing an adolescent on one of the ball fields, the robbery and murder of a student's grandparent witnessed by family members, terminal illnesses of both students and staff, sudden deaths of staff, the car-jacking and murder of a parent, tornadoes, and the murder/suicide of a staff member's relatives. Despite the potential for such crises, NOVA has observed that the majority of schools still seem to be unprepared for providing the needed crisis intervention response.

Even when a school is prepared, the shock and disbelief of the immediate crisis may render school personnel partially immobilized with helplessness. For instance, NOVA sent a crisis response team to assist the Theo J. Buell Elementary School in Mt. Morris Township, Michigan, following the shooting of Kayla Rolland, a six-year-old, first-grade student by her classmate in February 2000. One of NOVA's responders filed this report.

> The faculty at Buell Elementary School responded quickly. The teacher … was outside in the hall ... and moving her students to reading class. She quickly came back in and found Kayla. The other students … were evacuated from the room very quickly … The social worker, the principal and the janitor came to the room to aid the students, and they expressed a lot of feelings of helplessness as they were unable to assist Kayla … The school's plan was put into effect, and the students were locked in their rooms along with the teachers. The teachers remained calm in helping to calm the students, as many of the students heard the sound of gun firing (NOVA CRT Report, April, 2000).

While the Buell Elementary School staff initially responded well, they were still overwhelmed by the event and its aftermath—particularly the impact of the exhaustive convergence of the media. Perhaps the lessons learned from experiences such as this one can be condensed into three sentences: (1) Prepare and practice a crisis management plan; (2) Follow it when crisis happens; and (3) If the crisis is of a magnitude never experienced before, ask for outside help.

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Bell, C. C., & Jenkins, E. J. (1993). Community violence and children on Chicago's south side. *Psychiatry*, *56*, 46-54.

Bisson, J. I., & Deahl, M. P. (1994). Psychological debriefing and prevention of post-traumatic stress: More research is needed. *British Journal of Psychiatry*, *165*, 717-720.

Danieli, Y., Rodley, N. S., & Weisaeth, L. (Eds.). (1996). *International responses to traumatic stress*. Amityville, NY: Baywood Publishing.

Eitinger, L. (1964). *Concentration camp survivors in Norway and Israel*. Oslo, Norway: Universities Press.

Eitinger, L., & Strom, A. (1973). *Morbidity and mortality after excessive stress*. New York: Humanities Press.

Feuer, B. (1994). The Association of Flight Attendants Employee Assistance Program responds to workplace trauma: A dynamic model. In M. B. Williams & J. F. Sommer (Eds.), *Handbook of post-traumatic therapy* (pp. 310-324). Westport, CT: Greenwood Press.

Figley, C. R. (Ed.). (1985). *Trauma and its wake: The study and treatment of post-traumatic stress disorder*. New York: Brunner/Mazel.

Figley, C. R. (Ed.). (1995). *Compassion fatigue*. New York: Brunner/Mazel.

Galante, R., & Foa, D. (1986). An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. *Journal of the American Academy of Child Psychiatry*, *25*, 357-363.

Gillis, H. M. (1991). Children's responses and symptomatology following the Stockton, California school-yard shooting. In R. Belter (Chair), *Short-and long-term effects of trauma in children and adolescents*. Symposium conducted at the meeting of the American Psychological Association, San Francisco.

Green, B. L. (1993). Identifying survivors at risk: Trauma and stressors across events. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 135-144). New York: Plenum Press.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Jones, D. R. (1985). Secondary disaster victims: The emotional effects of recovering and identifying human remains. *American Journal of Psychiatry*, *142*, 303-307.

Kardiner, A. (1941). *The traumatic neuroses of war*. New York: Hoeber Press.

Kenardy, J. A., Webster, R. A., Lewin, T. J., Carr, V. J., Hazell, P. L., & Carter, G. L. (1996). Stress debriefing and patterns of recovery following a natural disaster. *Journal of Traumatic Stress*, *9*, 37-49.

Lindemann, E. (1994). Symptomatology and management of acute grief. *American Journal of Psychiatry*, *101*, 141-148.

Lindy, J. D. (1993). Focal psychoanalytic psychotherapy of posttraumatic stress disorder. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 803-809). New York: Plenum Press.

Lindy, J. D., & Wilson, J. P. (1994). Beyond empathy: New directions for the future. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. 389-394). New York: Guilford Press.

McCammon, S. L., & Allison, E. J. (1995). Debriefing and treating emergency workers. In C. F. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 115-130). New York: Brunner/Mazel.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder.* Waterloo, Ontario: Institute Press.

National Organization for Victim Assistance (1998, June). *Crisis response team report on Thurston High School in Springfield, Oregon, following the shooting on May 21, 1998.* Washington, DC: Author.

National Organization for Victim Assistance (2000, April). *Crisis response team report on Theo J. Buell Elementary School, Mt. Morris Township, Michigan following the shooting on February 29, 2000.* Washington, DC: Author.

Ochberg, F. M., & Soskis, D. A. (1982). *Victims of terrorism.* Boulder, Colorado: Westview Press.

Osofsky, J. D. (Ed.) (1997). *Children, youth, and violence: Searching for solutions.* New York: Guilford Press.

Parolotz, R. D. (1917). Recommendations for the treatment of mental and nervous diseases in the United States Army. *Psychiatric Bulletin, 2,* 355-376.

Perry, B. D. (1994). Neurobiological sequelae of childhood trauma: Post-traumatic stress disorders in children. In M. Murberg (Ed.), *Catecholamine function in post-traumatic stress disorder: Emerging concepts* (pp. 233-255). Washington, DC: American Psychiatric Press.

Pfeffer, C. R. (Ed.). (1997). *Intense stress and mental disturbance in children.* Washington, DC: American Psychiatric Press.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis, lessons learned: A resource for schools, parents, and communities.* Longmont, CO: Sopris West.

Pynoos, R. S., & Nader, K. (1993). Issues in the treatment of post-traumatic stress reactions in children and adolescents. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 535-549). New York: Plenum Press.

Pynoos, R. S., Steinberg, A. M., & Goenjian, A. (1996). Traumatic stress in childhood and adolescence: Recent developments and current controversies. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress* (pp. 331-358). New York: Guilford Press.

Raphael, B. (1983). *The anatomy of bereavement.* New York: Basic Books.

Raphael, B. (1986). *When disaster strikes: How individuals and communities cope with catastrophe.* New York: Basic Books.

Robinson, R. C., & Mitchell, J. T. (1993). Evaluation of psychological debriefings. *Journal of Traumatic Stress, 6,* 367-382.

Stallard, P., & Law, F. (1993). Screening and psychological debriefing of adolescent survivors of life-threatening events. *British Journal of Psychiatry, 163,* 660-665.

Stewart, J. B., Hardin, S. B., Weinrich, S., McGeorge, S., Lopez, J., & Pesut, D. (1992). Group protocol to mitigate disaster stress and enhance social support in adolescents exposed to Hurricane Hugo. *Issues in Mental Health Nursing*, *13*, 105-119.

Terr, L. (1990). *Too scared to cry*. New York: Basic Books.

Terr, L. (1994). *Unchained memories*. New York: Basic Books.

Ursano, R. J., McCaughey, B. C., & Fullerton, C. S. (1994). *Individual and community responses to trauma and disaster: The structure of human chaos*. Cambridge, England: Cambridge University Press.

van der Kolk, B. (1987). *Psychological trauma*. Washington, DC: American Psychiatric Press.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.) (1996). *Traumatic stress*. New York: Guilford Press.

Young, M. A. (1998). *Community crisis response team training* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

Yule, W. (1992). Post-traumatic stress disorder in child survivors of shipping disasters. The sinking of the "Jupiter." *Psychotherapy and Psychosomatics*, *57*, 200-205.

Endnote

[1] For further information regarding NOVA, write to National Organization for Victim Assistance, 1730 Park Road, NW, Washington, DC, 20010, or phone (202) 232-6682 or the 24-hour crisis line: (800) 879-6682. Information is also available online at *www.try-nova.org* or e-mail: *nova@try-nova.org*

18

危機

Estimating the Appropriate Crisis Response

Stephen E. Brock, Ph.D.
California State University, Sacramento

Following potentially traumatic events, crisis response teams must immediately begin to make a number of decisions regarding the form and substance of the crisis response. Typically, one of the first decisions made addresses what level of crisis response to provide. As currently conceptualized, the school crisis response may include several different levels of intervention intensity (Brock, 1998; Brock, Sandoval, & Lewis, 2000). These options, and a brief description of the circumstances under which each might be appropriate, are summarized in Table 1, on page 356. Obviously, the least intense crisis response option is to not provide a crisis team response at all. This response level is identified to acknowledge that there are a variety of common school stressors that are either not traumatic and/or affect very few individuals. Traditional school resources (e.g., individual school counselors and psychologists) can appropriately respond to these circumstances. In contrast, the most intense form of the crisis response will find a school district requesting intervention mutual aid support from other local, state, and/or national resources. Events that require this level of response are rare and are generated by stressors that are highly traumatic and affect many individuals. Falling between these two extremes are the school-site-level and the district-level crisis responses. Given the existence of these options, it is important for crisis response teams to be knowledgeable of the traumatizing potential of specific events. With this knowledge, teams will be in a better position to make more informed decisions about the intensity of a given crisis response.

Determining the appropriate level of crisis intervention response is critical for several reasons. First, school resources are limited, and the crisis response is an expensive and time-consuming activity. Thus, the judicious use of these services is prudent. Second, in most instances, school-site resources are in the best position to identify and respond to the needs of their individual students. Thus, it is preferable to have local, or site-level resources manage the crisis response as much as possible (Brock et al., 2000). Finally, it is important to remember that children, especially preschool and primary grade children, are sensitive to the anxiety of adults in their environment (Nader & Pynoos, 1993).

Table 1

Summary of Crisis Response Options

Response Option	Event Circumstances
No Response	The event is not traumatic, or traditional school resources can manage crisis reactions.
Site-Level Response	The event is traumatic; however, student crisis reactions can be managed by school-site-level crisis intervention services.
District-Level Response	The event is traumatic, and the severity of crisis reactions may overwhelm school-site-level crisis intervention services.
Mutual-Aid Response	The event is traumatic, and the severity of crisis reactions not only overwhelms school-site-level crisis intervention services but also district-level resources.

Thus, if personnel respond as if the event is very severe (when in fact it is not highly traumatic), there is a good chance that some students will be unnecessarily stressed.

From a review of the traumatic stress literature, this chapter provides crisis response teams with knowledge that can guide them in determining the required level of crisis response. This chapter presents information that crisis response teams can use in estimating the traumatizing potential of a given crisis event. Most of the research reviewed for this chapter used the presence of posttraumatic stress disorder (PTSD) symptoms to estimate the degree of potential traumatization. While other crisis reactions besides PTSD symptoms should be of concern to crisis response teams, PTSD reactions are an important and commonly accepted indicator of degree of traumatization. Thus, I believe PTSD research can help crisis response teams estimate the traumatizing potential of specific events. Before proceeding, however, I want to acknowledge that it is sometimes difficult to draw conclusions from this literature because of the tendency to use slightly different definitions and measures of trauma and traumatization. Nevertheless, I do believe that it is possible to make some generalizations.

Crisis Event Variables

In this chapter, those variables that genefate the traumatizing potential of a crisis event are identified as crisis event variables. These variables are the general, relatively objective, characteristics of a crisis event. Answers to the question: "What happened?" would provide crisis event variables. Specifically, these variables, which are summarized in Table 2, include the *crisis type*, the *crisis severity*, and the *number of individuals involved* in the crisis event. In Table 2 factors that decrease the traumatizing potential of an event are labeled "Traumatization Minimized." Those factors that increase such potential are labeled "Traumatization Maximized."

Table 2

Crisis Event Variables

Traumatization Minimized	Traumatization Maximized
Less traumatic crisis type	**More traumatic crisis type**
1. Predictable/Gradual onset	1. Unpredictable/Sudden onset
2. Nonassaultive injury and/or threat	2. Assaultive injury and/or threat
3. Natural disasters	3. Man-made disasters
4. Nonfatal trauma to significant other	4. Fatal trauma to significant other
Low crisis severity	**High crisis severity**
1. Brief crisis duration	1. Long crisis duration
2. Low crisis intensity	2. High crisis intensity
Few individuals involved	**Many individuals involved**

Crisis Type

The risk of psychological traumatization varies by the type of trauma experienced (Breslau, 1998; Carlson, 1997; Kilpatrick & Resnick, 1993; McFarlane & De Girolamo, 1996). Simply put, some crises are more traumatic than are others. Emphasizing this point is the suggestion that future research should explore the possibility that subtypes of PTSD are a function of the type of stressor (McFarlane & De Girolamo, 1996). In this discussion of crisis types I suggest that the risk of traumatization is influenced by the following: (a) crisis event predictability, (b) the source of injury and/or threatened injury, (c) the type of disaster (i.e., natural vs. man-made) and (d) the presence of fatalities.

First, it appears that relatively predictable and gradually unfolding crises (e.g., death following a long terminal illness, certain types of floods) are less traumatizing than those that are unpredictable and sudden (e.g., sudden unexpected death, earthquakes, random shootings). It has been suggested that if a crisis is more "predictable," there is more opportunity to prepare and to make cognitive and emotional adjustments. Thus, the event may be perceived as more controllable and consequently is less stressful (Saylor, Belter, & Stokes, 1997).

Second, it appears that injury or threatened injury/death as a result of war and/or assaultive violence is the most traumatic type of crisis. For example, PTSD rates exceeding 20% are reported in five studies of terrorist attack victims (with two studies reporting PTSD rates greater than 40%) (McFarlane & De Girolamo, 1996). Similarly, Breslau (1998), from data provided by the Detroit Area Survey of Trauma, reported a lifetime PTSD prevalence rate of 20.9% among those exposed to assaultive violence. Even higher estimates of psychological traumatization (following assaultive violence) are reported by Pynoos et al. (1987). This research found that 38.4% of children directly exposed to a schoolyard shooting displayed moderate to severe PTSD reactions. In contrast, it appears that injury or threatened injury/death not associated with war or assaultive violence is associated with a low risk of PTSD. For example, Breslau (1998) reported a lifetime PTSD prevalence rate of 2.3% among those in a serious car accident and 1.1% among those diagnosed with a life-threatening illness.

Third, it appears that natural disasters (e.g., floods, earthquakes) are less traumatizing than are man-made crises (e.g., war, assaultive violence) (Saylor, 1993). For example, Breslau (1998) reported a lifetime PTSD prevalence rate of 3.8% among those exposed to natural disasters. Similarly, Shore, Tatum, and Vollmer (1990) reported a PTSD rate of 3.6% among individuals exposed to the Mount St. Helens' volcanic disaster. In contrast, McFarlane and De Girolamo (1996) report that of the 21 studies that have examined PTSD among victims of man-made violence, only 3 reported a rate lower than 25%. In explaining the relatively low incidence of PTSD among survivors of natural disasters, it has been pointed out that these catastrophes do not necessarily involve human error or violence. Consequently, survivors are less likely to lose their faith and trust in people and society. Survivors also tend to be less stigmatized and are typically spared the "blame-the-victim" attitudes that often confront the survivors of man-made disasters (Matsakis, 1994).

Finally, it appears that simply learning about a *nonfatal* trauma (i.e., sexual/physical assault, serious injury/accident), experienced by a friend or relative, conveys the lowest risk of traumatization. For example, Breslau (1998) reported a lifetime PTSD prevalence rate of only 2.2% among those exposed to this type of trauma. In contrast, data from the same survey indicated that learning about the sudden unexpected *death* of a friend or relative was associated with a PTSD rate of 14.3%.

I offer an important caution here. Although research, such as the studies just mentioned, gives response teams a general idea of the type of events that will be most traumatic, it is important to remember that each event is unique. Events that are typically not highly traumatic may become overwhelming given the right set of circumstances. While it has been suggested that survivors of man-made crises suffer more than do the survivors of natural disasters (Matsakis, 1994), it appears that natural catastrophes that are extremely destructive and have a high death rate can be highly traumatizing. For example, Pynoos et al. (1993) reported that the rate of PTSD among a sample of survivors of the extremely destructive 1988 Armenian earthquake (which included children from two cities closest to the epicenter) was 91%! In addition, although learning of the sudden death of a significant other is typically associated with only a moderate risk of PTSD (14.3% according to Breslau, 1998), Milgram, Toubiana, Klingman, Raviv, and Goldstein (1988) reported that 40.7% of Israeli seventh-graders, who learned that 19 classmates had been killed in a school bus disaster, displayed PTSD reactions. These clear exceptions to the typical traumatizing potential of specific crisis types emphasize the importance of also considering the severity of the trauma when determining the appropriate level of crisis intervention response.

Crisis Severity

Numerous studies have suggested that the more severe the crisis event, the greater the likelihood of traumatization (Carlson, 1997; Kulka et al., 1990; Matsakis, 1994; Shalev, 1996). As defined by this author, crisis severity includes duration and intensity of the crisis.

Duration. The duration of the crisis refers to the amount of time that the event presents ongoing problems that are perceived by victims as unsolvable. Crisis events that last longer are generally associated with more severe distress (Matsakis, 1994; Saylor, 1993). A longer crisis duration is associated with greater feelings of uncontrollability and resulting anxiety, despair, and depression (Carlson, 1997). For example, although the earthquake experienced by Armenian children in the Pynoos et al. (1993) study was relatively brief, the damage and destruction it caused created long-term crisis problems that continued to be difficult to solve. Additional research, supporting the importance of crisis duration, suggests that the amount of time a solider is exposed to combat plays a critical role in the development of PTSD (Carlson, 1997; Frye & Stockton, 1982; Matsakis, 1994; Sonnenberg, Blank, & Talbott, 1985).

Intensity. The intensity of the crisis refers to the more extreme instances of crisis events. More intense crises are associated with greater amounts of property destruction and personal, physical, and emotional damage. The importance of this event variable is emphasized by Pynoos et al. (1987) who state: " … the extreme intensity of some situations will lead to initial symptoms [of traumatization] in virtually anyone" (p. 1061). For example, significant property damage and loss of life increased the intensity of the earthquake experience by Armenian children included in the Pynoos et al. (1993) study. Similarly, the intensity of the loss experienced by students included in the Milgram et al. (1988) study was increased by the 22 fatalities and 14 critical injuries generated by this bus disaster.

Additional research supporting the importance of crisis severity reports that veterans who were exposed to and/or participated in abusive violence/atrocities had higher rates of PTSD than those not so exposed (Sonnenberg et al., 1985). Breslau and Davis (1987) found that involvement in such atrocities accounted for 29% of the PTSD symptom variance, while other combat stress accounted for only an additional 6% of variance. Similarly, the intensity of a crime has been found to influence stress reactions. Victims of low-intensity crimes (e.g., burglary) have lower rates of PTSD than do victims of high-intensity crimes (e.g., those involving injury, a weapon and/or life-threat) (Chambless, Kilpatrick, & van der Kolk, 1990, as cited in Matsakis, 1994). Finally, the intensity of forced sexual assault (i.e., intercourse vs. fondling) has been found to be associated with severity of mental health problems (Carlson, 1997).

Number of Individuals Involved

The number of people involved in the crisis is the final variable to consider. Arguably, when it comes to estimating the required level of crisis response, this variable is perhaps most important. This variable comes not from research on traumatic stress, but from practical and logical considerations. Clearly, the number of people involved in a crisis event will play a critical role in determining the amount of crisis intervention support required (Brock et al., 2000). Simply put, the greater the number of individuals directly and/or indirectly exposed to a crisis, the more involved should be the crisis response.

When estimating the number of people involved in a crisis event, it is important to include not only those persons who would be considered trauma victims, survivors, and/or witnesses, but also those who had a relationship with the victims (i.e., friends and relatives). For example, in estimating the response required following an incident such as the previously mentioned Israeli school bus disaster (described by Milgram et al., 1988), a response team would not only identify accident survivors and witnesses as potential crisis intervention recipients, it would also include in this number those individuals who knew those who were killed. Following the Israeli school bus disaster, which had 22 fatalities, it is safe to assume that virtually everyone in the affected school community knew someone killed or injured in this catastrophe. Thus, this event involved a large number of individuals (at least an entire school) and required a very intense and involved crisis response.

Emergency response and media coverage. It is important to acknowledge that crisis event variables are also associated with various levels of emergency medical and police response and media coverage. More traumatic and severe crises will often bring onto school grounds more emergency response personnel. In addition, such events will be more newsworthy and will thus attract more media personnel. The need for/presence of these individuals (who are not normally a part of a school's staff) will create special crisis response needs. For example, such a presence will require that specific members of the school crisis response team be designated to act as liaisons with these non-school personnel. This will, of course, increase the required level of crisis response.

Crisis Response Estimation Guidelines

This chapter has provided information that will assist crisis response teams in estimating the traumatizing potential of a given crisis event. The importance of having this knowledge is highlighted by the tension between not wanting to overreact to a crisis versus being able to provide immediate support to those in crisis. If a crisis response team overestimates the level of response required, it runs the risk of unnecessarily stressing students and staff. For example, the presence of unfamiliar crisis intervention "experts," brought in to help manage a crisis situation, may suggest to students that a situation is so serious that their school cannot independently cope with the problem. If such crisis intervention support is not truly needed, then a crisis event may unnecessarily be made to appear more threatening. On the other hand, if a crisis response team underestimates the level of response required, it runs the risk of not having the resources available to immediately help students and staff adaptively cope with traumatic circumstances.

From the research reviewed in this chapter, I offer the following general crisis response estimation suggestions to help ease the tension between over- and underresponding. It is important to acknowledge, however, that individual schools and school districts will have different levels of naturally occurring support services. For example, while some schools have full-time counselors, others have very limited counseling resources. Thus, the availability of these services must also be considered when determining the level of response. In addition, it needs to be noted that each crisis event is unique, and the following are general guidelines; not hard and fast rules.

School-Level Response

To the extent possible, it is always preferable to have individual schools manage and respond to their own crisis situations. Not only does their knowledge of individual student and staff resources and vulnerabilities make them the most informed responders, but also such a response conveys that crisis problems are more solvable (relative to responses involving outside crisis intervention "experts"). This level of response may include not only a school-level crisis response team intervention, but also traditional support services (i.e., individual counselors or psychologists). The information presented in this chapter (and summarized in Table 2, on page 357) suggests that school-level resources should respond to less traumatic crisis types, which have lesser degrees of crisis severity. More specifically, individual schools might be expected to independently manage crises with the following characteristics:

1. events that result in nonassaultive injury (e.g., accidents);
2. events that involve learning of nonfatal trauma to another;
3. events that are brief in duration (e.g., present problematic circumstances for only a brief period of time);
4. events that are not unusually intense (e.g., have no unusual circumstances and/or few victims); and
5. events that affect relatively few individuals (e.g., few individuals are judged to perceive the event as threatening or dangerous).

This last characteristic is used to make the distinction between using traditional vs. school-level crisis response services. If only one or two students are affected, traditional resources might be adequate.

An important caution needs to be added regarding the decision to use traditional resources (vs. a crisis intervention response). The public has come to expect that schools will provide crisis intervention support following certain types of crisis events. Thus, a decision not to provide a crisis intervention, even when technically correct, may have certain public relations ramifications. For example, several years ago a special education bus was shot at on the way to school. Fortunately, none of the moderately to severely developmentally delayed students on the bus were injured. Further, the school bus driver and school principal determined that none of the children on the bus were aware of what had happened. Because of these facts, it was decided not to provide crisis intervention assistance to these students or to their classrooms. Despite the fact that the school's counselors met the bus and were available to assist students if needed, several parents became upset that the district crisis response team was not called upon following this event. They were aware of the fact that when other similar incidents had occurred, schools had responded immediately with a team of crisis intervenors. When such a response did not occur, they felt as if their situation was not being taken seriously. To take into account such feelings, it is recommended that immediate communication with parents take place whenever a decision is made not to provide a crisis intervention following potentially traumatic events. This communication should describe the crisis event, provide a description of the services that are available, and offer a rationale for why crisis intervention services are not being immediately provided. Possible rationales for not providing crisis intervention services might include the following:

1. students did not perceive this situation as dangerous or threatening,
2. if we were to help students understand the facts of the event (which is an important first step in the crisis intervention process) we would run the risk of unnecessarily frightening them, and
3. so few children were involved in (or affected by) the incident that our school counselor and psychologist will be able to assist affected students individually.

Recommendations for parents on how to be supportive to their children and what reactions might indicate the need for crisis intervention should also be included in such a communication.

Mutual-Aid-Level Response

Although rare, some crisis events clearly will require the most extreme level of crisis response. The mutual-aid-level response, which involves bringing into a school district outside local, state, and/or national resources, is employed when local school and district resources are overwhelmed (Brock, 1998). The information presented in this chapter (and summarized in Table 2, on page 357) suggests that the most traumatic crisis types, which have greater degrees of crisis severity, may require a mutual-aid crisis response. More specifically, mutual-aid support might be required in response to crises with the following characteristics:

1. assaultive and/or man-made events that result in actual and/or threatened injury or death;
2. events that are long in duration (e.g., present problematic circumstances for an extended period of time);
3. events that are unusually intense (e.g., have unusually stressful circumstances, result in significant property destruction, and/or have many severe injuries and/or fatalities); and
4. events that involve most if not all of a school's student body.

District-Level Response

Falling between the school-level response and the mutual-aid response is the district-level response. Although more common than the mutual-aid response, the district-level response is also implemented relatively infrequently. The information presented in this chapter (and summarized in Table 2) suggests that more traumatic crisis types, which have lesser degrees of crisis severity, or less traumatic crisis types, which have greater degrees of severity, may require a district-level crisis response. Because it is preferable to have school resources manage a crisis event to the greatest degree possible, it may be appropriate to mobilize a district-level crisis response team and then place it on standby. In this way, a school-level response can be initiated, and outside crisis intervenors immediately brought in only after the school resources are judged insufficient.

Concluding Comments

This chapter is intended to facilitate understanding of the traumatizing potential of various crisis events. Simply put, some crisis events tend to be more traumatic than are others. Review of posttraumatic stress research suggests that sudden, man-made disasters, involving assaultive injury and/or threat, and/or fatalities have the potential to be highly traumatic. At the same time, however, each crisis event is unique and, given the right set of circumstances, virtually any crisis may become highly traumatic. Thus, it is also important to consider the intensity and duration of the crisis event when estimating traumatizing potential. Any crisis event that is unusually intense and lasts a long time has the potential to be highly traumatic. The information provided in this chapter may allow crisis response teams to better estimate the appropriate level of crisis response needed. Doing so is important because of the dangers associated with both over- and underreacting to a crisis event.

References

Breslau, N. (1998). Epidemiology of trauma and posttraumatic stress disorder. In R. Yehuda (Ed.), *Psychological trauma* (pp. 1-29). Washington, DC: American Psychiatric Press.

Breslau, N., & Davis, G. C. (1987). Posttraumatic stress disorder: The etiological specificity of wartime stressors. *American Journal of Psychiatry, 144*, 578-583.

Brock, S. E. (1998, November). School crisis intervention mutual aid: A county-level response plan. NASP *Communiqué, 27*(3), 4-5.

Brock, S. E., Sandoval, J., & Lewis, S. (2000). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Carlson, E. B. (1997). *Trauma assessments: A clinician's guide*. New York: Guilford Press.

Chambless, D., Kilpatrick, D., & van der Kolk, B. (1990, March). *Symposium on posttraumatic stress disorder*. Symposium conducted at the meeting of the Anxiety Disorders Association of America Tenth National Conference, Bethesda, MD.

Frye, S., & Stockton, R. (1982). Discriminant analysis of PTSD among a group of Vietnam veterans. *The American Journal of Psychiatry, 139*, 52-56.

Kilpatrick, D. G., & Resnick, H. S. (1993). PTSD associated with exposure to criminal victimization in clinical and community populations. In J. R. T. Davidson & E. B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and beyond* (pp. 113-143). Washington, DC: American Psychiatric Press.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1990). *Trauma and the Vietnam War generation*. New York: Brunner/Mazel.

Matsakis, A. (1994). *Post-Traumatic Stress Disorder: A complete treatment guide*. Oakland, CA: New Harbinger.

McFarlane, A. C., & De Girolamo, G. (1996). The nature of traumatic stressors and the epidemiology of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 129-153). New York: Guilford Press.

Milgram, N. A., Toubiana, Y. H., Klingman, A., Raviv, A., & Goldstein, R. (1988). Situational exposure and personal loss in children's acute and chronic stress reactions to a school bus disaster. *Journal of Traumatic Stress, 1*, 339-352.

Nader, K., & Pynoos, R. (1993). School disaster: Planning and initial interventions. *Journal of Social Behavior and Personality, 8*, 1-22.

Pynoos, R. S., Frederick, C., Nader, K., Steinberg, A., Eth, S., Nune, F., & Fairbanks, L. (1987). Life threat and post traumatic stress in school-age children. *Archives of General Psychiatry, 44*, 1057-1063.

Pynoos, R. S., Goenjian, A., Tashjain, M., Karakashian, M., Manjikian, R., Manoukian, G., Steinberg, A. M., & Fairbanks, L. A. (1993). Post-traumatic stress reactions in children after the 1988 Armenian earthquake. *British Journal of Psychiatry, 163*, 239-247.

Saylor, C. F. (1993). *Children and disasters*. New York: Plenum.

Saylor, C. F., Belter, R., & Stokes, S. J. (1997). Children and families coping with disaster. In S. A. Wolchik & I. N. Sandler (Eds.), *Handbook of children's coping: Linking theory and intervention* (pp. 361-383). New York: Plenum.

Shalev, A. Y. (1996). Stress versus traumatic stress: From acute homeostatic reactions to chronic psychopathology. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 77-101). New York: Guilford Press.

Shore, J. H., Tatum, E. L., & Vollmer, W. M. (1990). The Mount St. Helens' stress response syndrome. In J. H. Shore (Ed.), *Disaster stress studies: New methods and findings* (pp. 78-97). Washington, DC: American Psychiatric Press.

Sonnenberg, S. M., Blank, A. S., & Talbott, J. A. (Eds.) (1985). *The trauma of war: Stress and recovery in Vietnam veterans.* Washington, DC: American Psychiatric Press.

19

Identifying Individuals at Risk for Psychological Trauma

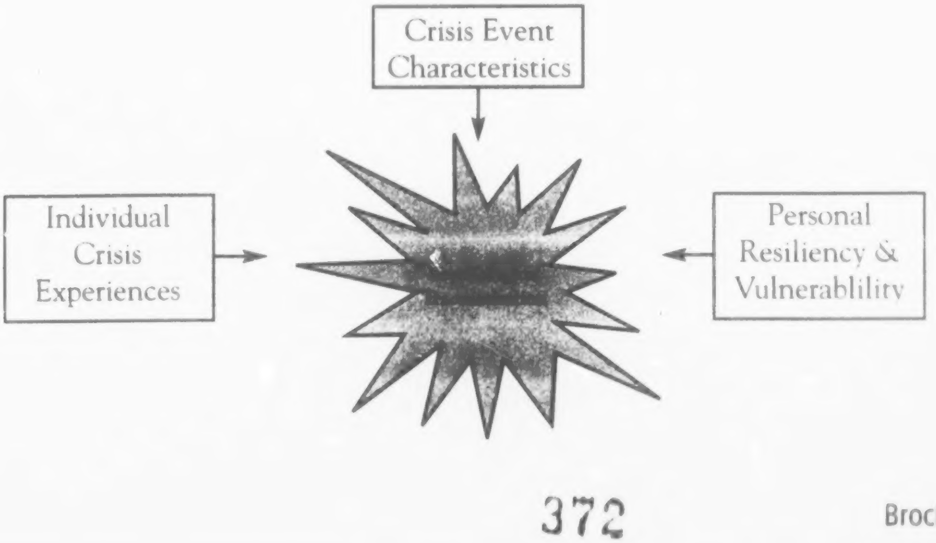
危
機

Stephen E. Brock, Ph.D.
California State University, Sacramento

As Chapter 18 illustrated, crisis events vary in their potential to traumatize. Even for a specific event, however, there is no simple cause-and-effect relationship between the crisis and subsequent traumatization (Carlson, 1997). In other words, a given crisis event will not result in the same degree of traumatization among all survivors. As illustrated in Figure 1, one conceptualization of traumatization is as a consequence of the interaction among the crisis event, the individual's unique crisis experience, and personal resiliency and vulnerability. Traumatization is not simply a consequence of what happened; it is also a consequence of how survivors experience the crisis (individual crisis experience variables) coupled with the personal characteristics of the survivors (personal resiliency and vulnerability variables).

Figure 1

Psychological traumatization is the result of the interaction among the characteristics of the crisis event, individual crisis experiences, and personal resiliency and vulnerability.


Crisis Event Characteristics
Individual Crisis Experiences
Personal Resiliency & Vulnerablility

Individual Crisis Experience Variables

Individual crisis experience variables include *crisis exposure*, *relationships with crisis victims*, *crisis reactions*, and *perceived threat*. These variables are the unique, relatively subjective, crisis experiences of the individual. These variables can either increase or decrease the traumatizing potential of an event depending upon their presence or absence (see Table 1).

Table 1

Individual Crisis Experience Variables

Traumatization Minimized	Traumatization Maximized
Low Crisis Exposure	**High crisis exposure**
1. Not proximal to the crisis event	1. Proximal to the crisis event
2. Brief exposure to the crisis event	2. Long exposure to the crisis event
No relationship with victim(s)	**Close relationship with victim(s)**
No crisis reactions	**Severe crisis reactions**
1. Management of initial reactions	1. Initial response of panic/dissociation
2. Over time arousal normalizes	2. Over time arousal does not normalize
Low perceived threat	**High perceived threat**

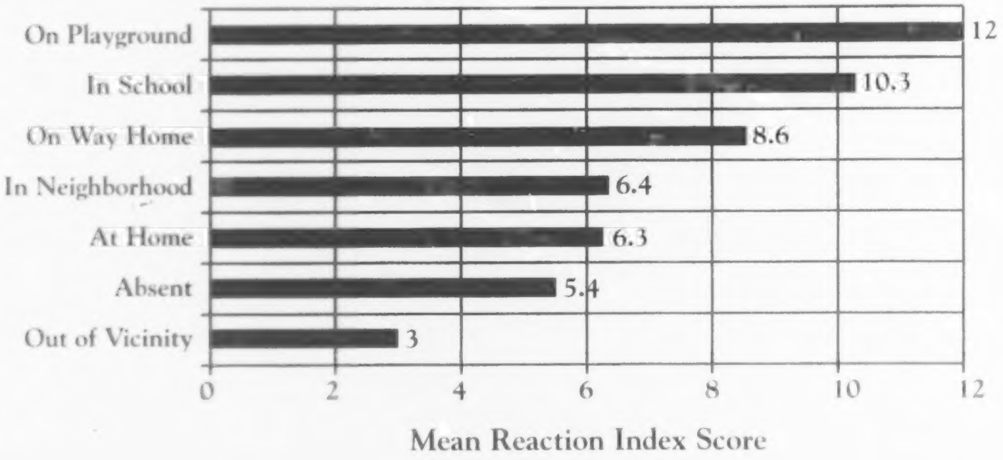
Crisis Exposure

Individual exposure includes proximity and duration of exposure to a crisis event. The closer the individual is to the crisis and the longer the duration of exposure, the greater the traumatization.

Proximity to the crisis. The effect of proximity has frequently been documented by traumatic stress research (Bloch, Silber, & Perry, 1956; Callahan, 2000; Green, Grace, & Lindy, 1983; Green et al., 1991; McFarlane, 1986; Nader, Pynoos, Fairbanks, & Frederick, 1990; Newman, 1976; Shore, Tatum, & Vollmer, 1986, 1990). Pynoos et al. (1987), for example, demonstrated the dominant influence of exposure to a crisis event in predicting the development of posttraumatic stress reactions. This study assessed the self-reports of children's (ages 5 to 13) stress reactions following a sniper attack on a school playground that left one student and one passerby killed and 13 wounded. Making use of a Posttraumatic Stress Disorder (PTSD) Reaction Index, a strong (almost linear) relationship between proximity and PTSD symptoms was demonstrated (see Figure 2). Therefore, all individuals directly involved in and/or exposed to a crisis event should be given a high priority for crisis intervention assistance.

Figure 2

Mean PTSD Reaction Index scores (which reflect the number of PTSD symptoms reported) by exposure to a playground shooting. Number of symptoms increases as degree of exposure increases. ANOVA indicated significant differences between mean scores (F = 16.06, *df* = 6, *p* < .001).



Note
From "Life Threat and Posttraumatic Stress in School-Age Children," by R. S. Pynoos et al., 1987, *Archives of General Psychiatry, 44*, p. 1059. Copyright 1987 by the American Medical Association. Reprinted with permission.

Duration of exposure to the crisis. Generally speaking, crisis events that last longer are associated with more severe distress (Matsakis, 1994; Saylor, 1993). Thus, duration of exposure to the traumatic event is also an important consideration in determining crisis intervention service priority. For example, following a schoolyard shooting, relatively high crisis intervention priority would be given to students trapped on the playground by gunfire. In contrast, a relatively lower priority would be given to those who were quickly able to escape to a safe location.

Although crisis exposure is clearly a dominant factor in determining initial psychological traumatization, even individuals not exposed to the stressor may report distress. While the most severe PTSD reactions reported in the Pynoos et al. (1987) study were documented among children on the playground during the shooting, some children who were not even at school at this time also displayed PTSD reactions (17.5% reported moderate to severe reactions). Thus, it is clear that other factors must be considered when identifying psychological trauma victims. These factors will now be discussed.

Relationship With Crisis Victims

Besides exposure to the crisis event, relationship with the crisis victims is one of the most powerful traumatization risk factors. The stronger the relationships, the greater the likelihood of traumatization (Nader & Pynoos, 1993). The importance of this factor has been demonstrated by Nader et al. (1990) and Pynoos et al. (1987), who found that greater acquaintance with the victim of a schoolyard shooting was positively correlated with higher PTSD Reaction Index scores. Similarly, Milgram, Toubiana, Klingman, Raviv, and Goldstein (1988) found both acute and chronic stress reactions, following a bus-train collision, to be more related to friendship with accident victims than to exposure to (witnessing) the school bus disaster. Therefore, individuals who are emotionally close to a trauma victim should also be given a high priority for crisis intervention assistance.

Severity of the Survivor's Acute Distress

The individual's emotional reaction to the crisis is also an important variable to consider. Not only does the immediate response to a crisis influence the capacity to respond adaptively, but it also appears that those who display more severe reactions are at greater risk for psychological traumatization (Matsakis, 1994). For example, research with veterans of the 1982 Lebanon War found that soldiers who became acutely distressed during the conflict had a much higher rate of PTSD. Conversely, soldiers who were able to manage their feelings during combat displayed a significantly lower rate of this disorder. Generally, individuals who display dissociative or panic reactions during a trauma are more vulnerable to posttraumatic reactions (McFarlane & Yehuda, 1996).

Research also suggests that specific types of trauma reactions may define high-risk trauma victims. Specifically, McFarlane and Yehuda (1996) found that "enduring exaggerated startle response, hypervigilance, increased irritability, sleep disturbance, and disturbed memory and concentration" (p. 172) differentiated trauma survivors who developed PTSD from those who did not. Conversely, they suggest that distressing and intrusive memories, in the initial days after the crisis event, were common indicators of normal reappraisal.

These data suggest that crisis victims who report or appear to be experiencing extreme stress reactions should be given a high priority for crisis intervention assistance. Particular attention should be directed to those who panic or dissociate during the trauma and who have ongoing difficulty regulating their arousal levels.

Perceived Threat

Finally, the crisis victim's subjective impression of the crisis can be more important than the crisis event itself (McFarlane & De Girolamo, 1996). Thus, it is important to assess not only objective traumatizing factors, such as exposure to the crisis, but also the subjective threat experienced by victims. Simply stated, traumatized individuals will have perceived the event as extremely negative (Caplan, 1964; Carlson, 1997; Mitchell & Everly, 1996). Conversely, individuals who did not perceive the event as severe, regardless of how dangerous and intense it actually was, will not be as traumatized. For example, Tatum, Vollmer, and Shore (1986) found that perceived threat resulting from the Mount St. Helens' volcanic disaster was significantly correlated with stress reactions. In addition, King, King, Fairbank, Keane, & Adams (1998) reported a direct relationship between perceived threat and traumatic stress among male Vietnam veterans. It is important, therefore, to assess perceived threat when determining priorities for individual crisis intervention service.

Factors influencing children's threat perceptions. It is critical to keep in mind the impact of adult reactions on children's perceptions. Events that are initially not perceived as threatening may become such after observing the reactions of others. For example, Pynoos et al. (1987) reported that children who were dramatically confronted with indications of the severity of a school shooting (e.g., having their home used as emergency headquarters for a SWAT team) displayed more PTSD reactions than did other similarly trauma-exposed children. In this instance, the children's observations of extreme adult reactions may have elevated their perception of crisis threat.

In addition, it is important for crisis intervenors to keep in mind that children may view a crisis (such as being held at gunpoint) as nonthreatening because they are too developmentally immature to understand the potential danger. Given this circumstance, the event may become traumatic only if the danger of the situation is explained to them (Carlson, 1997). It appears that, at least when it comes to initial traumatization, developmental immaturity might be protective. Specifically, lack of cognitive sophistication may result in a child not understanding the magnitude of even the most severe of crises. Conversely, relative cognitive sophistication may make a young child more vulnerable to understanding the magnitude of a traumatic event (Masten & Coatsworth, 1998). Because of their higher levels of sensitivity to the environment, these children may be more susceptible to stressors (Luthar & Zigler, 1991). The observations of Green et al. (1991) support this hypothesis. These researchers, who examined the psychiatric reports of children made 2 years after a dam failure disaster, found younger children (ages 2 to 7) had fewer PTSD symptoms than did older youths (ages 8 to 15). They speculated that very young children's initial experience of disaster might have been limited by their cognitive abilities. These children may not have been aware of the threat presented by the dam failure. Further, they were found to be more influenced by parental reactions (i.e., severity of parents' PTSD symptoms) than by crisis exposure. Therefore, it is suggested that the interaction between students' developmental level and crisis threat perceptions should be considered when determining crisis intervention service priorities.

Personal Resiliency and Vulnerability Variables

Personal resiliency and vulnerability variables include both *external* and *internal* factors (see Table 2, on page 372). External factors are found within the individual's environment and include familial, social, and financial resources. Internal factors are more difficult to directly observe. These variables, which are relatively stable factors existing within the individual, include: coping style, mental health history, emotional self-regulation, developmental level, trauma history, self-esteem, locus of control, and religious belief systems. Individuals who are less resilient will typically require more extensive services than do those with greater resilience.

Table 2

Personal Resiliency and Vulnerability Variables

	Resiliency Factors	Vulnerability Factors
External	**Familial resources available**	**Familial resources unavailable**
	1. Living with nuclear family member	1. Not living with nuclear family
	2. Effective & caring parenting	2. Ineffective & uncaring parenting
	3. Extended family relations/ guidance	3. Family dysfunction (e.g., alcoholism, violence, mental illness)
	4. Caregivers cope well with trauma	4. Parental PTSD
		5. Child maltreatment
	Social resources available	**Social resources unavailable**
	1. Close peer friendships	1. Social isolation. Lack of perceived social support
	2. Access to positive adult models	
	3. Connection with prosocial institutions	
		Financial resources unavailable
Internal	1. Active coping style	1. Avoidance coping style
	2. Mental health	2. Preexisting mental illness
	3. Good self-regulation of emotion	3. Poor self-regulation of emotion
	4. Developmental maturity and higher IQ	4. Low developmental level
	5. Adaptive coping with prior trauma	5. History of prior traumatization
	6. High self-esteem	6. Low self-esteem
	7. Internal locus of control	7. External locus of control
	8. Religious belief system (faith)	

Personal resiliency and vulnerability variables play a role in both the initial and long-term reactions to a psychological trauma. My interpretation of current research suggests that these variables are a more powerful influence on long-term trauma reactions than on initial adjustment. Some crisis events may be so overwhelming that they result in *initial* traumatization in virtually everyone, and personal resiliency will not reduce their impact (Pynoos et al., 1987). In contrast, some researchers have concluded that maladaptive *long-term* adjustment to a trauma is not typical. For example, Breslau (1998) has documented that, although there was an 89% lifetime prevalence of exposure to traumatic events in her 1996 Detroit Area Survey of Trauma, only 10.2% of males and 18.3% of females developed PTSD. Findings such as these suggest that personal vulnerability distinguishes those who develop chronic PTSD from those who do not (Breslau, 1998; McFarlane, 1990; McFarlane & Yehuda, 1996).

External Personal Resiliency and Vulnerability Variables

Familial Resources

Living with nuclear family members. Simply being able to continue to live with a nuclear family member following a trauma appears to promote resiliency. Supporting this observation is the finding that traumatized Cambodian refugee youths not living with a nuclear family member, and instead residing with a foster family, had poorer long-term adjustment (Kinzie, Sack, Angell, Manson, & Rath, 1986). Conversely, those youths who were able to reestablish contact and live with any family member did much better. Kinzie et al. concluded that ". . . having reestablished some contact with family members in this setting mitigated some of the symptoms of the severe trauma, while being alone or in a foster family exacerbated the disorder" (p. 375). This finding may be related to the fact that the loss of a family member means not only the removal of an important attachment system, but also part of the individual's "meaning system." The individual can never again be son or brother, daughter or sister, if his or her family has been completely lost (Matsakis, 1994).

Family functioning. Level of family functioning plays an important role in determining the severity of posttraumatic symptomology (Caplan, 1964; Carlson, 1997; Luthar & Zigler, 1991; Terr, 1983). Especially important in how youths respond to stress is the quality of the parent-child relationship. Adaptive long-term outcomes require the involvement of caring, affectionate, and competent parents (or other primary caregivers) in the child's life. Specific parenting characteristics that have been associated with resiliency include warmth, structure, and high expectations. Access to warm relationships and guidance from the extended family is also associated with resiliency (Doll & Lyon, 1998).

Family violence. Creating perhaps even more vulnerability then ineffective parenting are experiences with maltreatment. For example, a study of Vietnam combat veterans found that those with PTSD had higher rates of childhood physical abuse than did those without this disorder (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993).

Family mental health. The presence of mental illness within the family will increase vulnerability to a traumatic stressor (Bloch et al., 1956; Green et al., 1991). For example, following a school bus kidnapping, Terr (1983) found " ... relationships between the clinical severity of the children's posttraumatic conditions and their preexisting family pathology ... " (p. 1550). Therefore, the mental health of family members should also be considered (Lystad, 1985; Nader & Pynoos, 1993).

Caregiver reactions to the trauma. Finally, how the family copes with a trauma is also important, because the reactions of others can have a significant impact on how youths view traumatic events. For example, Green et al. (1991) reported that greater maternal PTSD predicted greater child PTSD two years following a dam collapse and flood. Similarly, Nader and Pynoos (1993) point out that "there is a commonalty in the level of anxiety among children and the adults in their environment" (p. 17).

Clearly, students from more stable families will demonstrate greater resilience following traumatic events (Luthar & Zigler, 1991). Conversely, youths who lack these protective family resources should be made a priority for crisis intervention services. Special attention should be directed toward persons not living with family members, from dysfunctional homes, with mental illness, and whose caregivers are having special difficulty coping with the trauma.

Social Resources

Several specific school and community social resources have been shown to promote resiliency (Doll & Lyon, 1998). These resources include close peer friendships, access to positive adult models outside of the family, and strong connections to prosocial organizations or institutions. Positive school experiences (academic or nonacademic) have also been found to be a protective factor (Luthar & Zigler, 1991). Individuals who have social supports available to them are expected to show lower levels of acute distress following a crisis event. Conversely, individuals who must face a crisis without supportive and nurturing friends or relatives have been shown to suffer more than those who have at lease one source of such care (Caplan, 1964; Carlson, 1997; King et al., 1998; Lyons, 1991; Terr, 1983). Given these reports, individuals known to be socially isolated (or who perceive themselves as such) should be given crisis intervention service priority.

Financial Resources

Adequate financial support or services can also influence adjustment following trauma (Lyons, 1991; Slaikeu, 1990). Childhood poverty has been found to be a consistent predictor of dysfunction in adulthood (Doll & Lyon, 1998). An example of how this variable can influence the adjustment to a stressor is offered by Lewis (1970), whose qualitative study of a poor family dramatically illustrated how the stress associated with the death of a loved one was compounded by funeral and burial costs.

Internal Personal Resiliency and Vulnerability Variables

Coping Strategies

The types of strategies used by individuals to cope with problems may also serve to mediate the impact of a traumatic stressor. Resiliency research has suggested theoretical frameworks of coping that include distinctions between active (or approach) and avoidance coping strategies (Ayers, Sandler, West, & Roosa, 1996; Ebata & Moos, 1994). Active coping strategies include thoughts and actions that focus directly on problems (e.g., positive thinking, positive reappraisal of the stressor, making problem-solving decisions, and taking some direct action). Avoidance coping strategies include thoughts and actions that attempt to focus away from a stressful situation (e.g., to stop thinking about and/or dealing with the stressor; Sandler, Wolchik, MacKinnon, Ayers, & Roosa, 1997).

Resiliency research examining the effects of different coping strategies has found that the use of active coping, when dealing with stressful situations, is consistently associated with a reduced incidence of mental health problems (Sandler et al., 1997). In other words, confronting the traumatic stressor and engaging in cognitive and behavioral efforts to directly solve crisis-related problems is associated with better mental health outcomes. Conversely, the use of avoidance coping is consistently associated with an increased incidence of mental health problems in children and adolescents. Directing one's focus away from the traumatic stressor and engaging in cognitive and behavioral efforts to avoid crisis-related problems is associated with poorer mental health outcomes.

Although it appears that active coping is preferable to avoidant coping, avoidant coping may not be a risk factor in all circumstances. Sandler, Tein, and West (1994) suggest that in extremely high-stress situations, an initial avoidance coping response may be adaptive. Such a response may help to reduce negative arousal and thereby give the individual time to mobilize active coping resources. Thus, the individual who engages in avoidant coping immediately following a highly traumatic event may not necessarily be at increased risk for mental health problems. Clearly, however, the individual who continues to employ avoidance coping as a long-term, problem-solving strategy is more likely to have a poorer mental health outcome. These individuals should be given crisis intervention service priority.

Mental Health

Although entry into a crisis state is not in and of itself a sign of mental illness, a history of such illness can lower resistance to crises. There is evidence that a preexisting mental disorder influences the development of acute distress (American Psychiatric Association, 1994; Breslau, 1998), and psychiatric and personality disorders may increase vulnerability to traumatic crises (McFarlane, 1990; Nader & Pynoos, 1993).

For example, Breslau (1998) reports that preexisting major depression and anxiety disorders increase the risk of PTSD. Thus, individuals with mental illness should be given crisis intervention service priority.

Self-Regulation of Emotion

Masten and Coatsworth (1998) suggest that because of temperament, some children may be more prone to severe emotional reactions (e.g., anxiety and distress). These are children who have relative difficulty regulating negative emotions and do not regroup as readily when confronted with stressful experiences. Conversely, adaptive long-term outcomes are associated with a lower reactivity to stress and greater self-control of behavior. Thus, individuals known to have a negative temperament, be easily upset, and have difficulty calming down should be given crisis intervention service priority.

Developmental Level and Intellectual Functioning

While developmental immaturity may be a protective factor when it comes to initial traumatization (i.e., younger children may not comprehend the actual threat of the trauma), once an event is judged threatening, and all other factors are held constant, the younger the crisis survivor, the greater the traumatization (Carlson, 1997). Support for this observation is offered by Schwarz and Kowalski (1991), who found that while only 19% of adults exposed to a school shooting could be diagnosed as having PTSD, 27% of children could be diagnosed with this disorder. This difference may result from the greater vulnerability of younger children and their lack of experience coping with difficult problems. King, King, Foy, and Gudanowski (1996) found that soldiers who were younger when they went to war were more likely to have postwar PTSD symptoms, suggesting that younger men had not obtained a sufficient level of emotional development to cope with the stressors of combat.

Resiliency is clearly promoted by good intellectual functioning (Doll & Lyon, 1998). Masten and Coatsworth (1998) suggest that higher IQ scores may be associated with enhanced information-processing skills that help children cope with adversity. Children who are more intelligent may also be better able to solve problems and protect themselves. Conversely, children with lower IQ scores may find it more difficult to deal with threatening situations or fail to learn as much from prior experiences. Therefore, developmentally younger trauma victims (especially those with lower IQs) should be given relatively high crisis intervention service priority when compared with more mature (more intelligent) survivors.

Trauma History

A history of prior traumatization increases vulnerability to future traumatization (Bremner et al., 1993; Breslau, 1998; Matsakis, 1994). For example, a school shooting will be more traumatic for students who have previously been the victims of violence (e.g., child abuse). Children who have experienced repeated traumatic stressors are more likely to disassociate and display mood swings than single-incident crisis survivors (Terr, 1991). Nader et al. (1990) reported that following a sniper attack on their school, children who had experienced previous traumas had renewed PTSD symptoms related to the earlier experiences. When exploring trauma history it is also important to identify individuals who have experienced prior crises similar in nature to the current crisis event, because these individuals may be at particular risk (Horowitz, 1986; Nader & Pynoos, 1993).

Although the role of prior traumatization is typically thought to increase vulnerability, some have suggested that prior life crises may inoculate individuals from future traumatization (Caplan, 1964; Carlson, 1997; Horowitz, 1986). In other words, the strategies developed to solve problems generated by prior crises may help the individual cope more effectively with future events. Norris and Murrell (1988) have conducted research supporting this "inoculation hypothesis." In this study, 234 older adults (ages 55 to 75+) were interviewed both before and after a serious flood. Statistical analysis found that the flood exposure accounted for a significant amount of the variance in anxiety and distress only among those who had *no prior experience* with a flood. Among those who did have prior flood experience, the current flood did not account for a significant amount of variance in their emotional states. Flood survivors without prior flood experience had sharply increased anxiety and distress when faced with personal loss (as measured by victims' perceptions). In contrast, symptoms of anxiety and distress among those with prior flood exposure remained close to preflood levels regardless of degree of personal loss. However, because this research was conducted with older adults, these findings may not be generalizable to children and/or other traumatic events.

While it is possible that prior exposure to a traumatic stressor (such as a flood) will facilitate coping with future traumatic events, it is also likely that traumatic stressors have some negative long-term effects. For example, among the flood victims studied by Norris and Murrell (1988), significant increases in anxiety and distress were seen only among those without prior experience with a disaster, but those with previous trauma experience had slightly higher levels of these emotions before the crisis event. Similarly, Luthar (1991) found high levels of distress among adolescents who, despite living in stressful environments, were judged successful. Masten and Coatsworth (1998) cite other research that did not find evidence of distress among adolescents who had successfully coped with adversity. Nevertheless, they conclude: "It remains an important question for future research whether, and under what conditions, children carry forward long-term consequences of adversity despite manifest competence and whether it is a sign for concern" (p. 213).

Other Internal Resiliency and Vulnerability Factors

A variety of other factors are identified by the resiliency literature as influencing adjustment to stressors; however, given the scope of this chapter, a thorough treatment of the resiliency literature is not possible. Nevertheless, I would like to briefly mention several other variables that have been suggested as important to the adjustment to stressful life events. These factors are, however, often difficult to observe and may not have great practical utility during the initial psychological triage of crisis victims.

Self-confidence and esteem. Self-esteem has been found to be an important coping resource (Doll & Lyon, 1998; Masten & Coatsworth, 1998). According to Lutzke, Li, Ayers, and Sandler (1995, as cited in Lutzke, Ayers, Sandler, & Barr, 1997), high self-esteem significantly reduces depression, anxiety, and conduct disturbances following negative life events.

Locus of control. An internal locus of control has also been found to serve as a resiliency factor for youths (Doll & Lyon, 1998; Luthar & Zigler, 1991; Masten & Coatsworth, 1998). Specifically, youths who have faith in their ability to control their environment are better able to cope with stressful life events (Werner & Smith, 1982). Conversely, youths with an external locus of control have been found to display increased levels of psychological symptomatology following negative life events (Lutzke, Li, Ayers, & Sandler, 1995, as cited in Lutzke, Ayers, Sandler, & Barr, 1997; Silverman & Worden, 1992).

Resilient faith or belief system. Finally, the presence of a religious belief system during times of stress can be an important internal coping resource (Doll & Lyon, 1998; Luthar & Zigler, 1991; Masten & Coatsworth, 1998). Not only does it provide an intellectual framework that makes many events (e.g., the death of a loved one) more understandable, but it also typically includes a community (e.g., a congregation) that is able to provide needed support (Lutzke, Ayers, Sandler, & Barr, 1997). Research has found religion to be helpful for both adults (McIntosh, Cohen, Silver, & Wortman, 1993) and youths (Gray, 1987) following the death of a loved one.

Concluding Comments

The information presented in this chapter will be especially useful when responding to crises that have many more victims than crisis intervenors. In this circumstance crisis intervention treatment priority decisions must be made, because not all individuals affected by the crisis can be seen right away. Thus, those individuals at greatest risk for psychological trauma will need to be identified and made crisis intervention priorities. Conversely, those individuals judged at low risk for traumatization will need to be made relatively low crisis intervention priorities. Knowledge of the variables that result in traumatization is critical to conducting such "psychological triage."

This chapter has suggested that a number of variables may play a role in psychological traumatization. Although crisis exposure has been suggested to play a primary role in traumatization, other variables such as familiarity with crisis victims, crisis reactions, threat perceptions, and personal resiliency and vulnerability factors are also involved. Thus, I suggest that these risk factors be considered collectively when determining crisis intervention service priorities. Further, I recommend that crisis experience and external resiliency and vulnerability variables be considered first when conducting an initial psychological triage. For school-based crisis intervenors, these factors are relatively easy to assess and thus are most helpful in making quick treatment priority decisions. Internal personal resiliency and vulnerability variables may have their greatest utility when it comes to making long-term treatment decisions. These variables may be especially helpful in making the distinction between those who are likely to successfully resolve a crisis from those who are likely to have ongoing difficulties (e.g., to develop chronic PTSD). For further information on conducting psychological triage, as well as specific psychological triage tools, the reader is referred to Brock, Sandoval, and Lewis (2000).

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Ayers, T. S., Sandler, I. N., West, S. G., & Roosa, M. W. (1996). A dispositional and situational assessment of children's coping: Testing alternative models of coping. *Journal of Personality and Social Psychology, 51*, 1173-1182.

Bloch, D. A., Silber, E., & Perry, S. E. (1956). Some factors in the emotional reactions of children to disaster. *The American Journal of Psychiatry, 113*, 416-422.

Bremner, J. D., Southwick, S. M., Johnson, D. R., Yehuda, R., & Charney, D. S. (1993). Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry, 150*, 235-239.

Breslau, N. (1998). Epidemiology of trauma and posttraumatic stress disorder. In R. Yehuda (Ed.), *Psychological trauma* (pp. 1-29). Washington, DC: American Psychiatric Press.

Brock, S. E., Sandoval, J., & Lewis, S. (2000). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Callahan, J. (2000). Predictors and correlates of bereavement in suicide support group participants. *Suicide & Life-Threatening Behavior, 30*, 104-124.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Carlson, E. B. (1997). *Trauma assessments: A clinician's guide*. New York: Guilford Press.

Doll, B., & Lyon, M. A. (1998). Risk and resilience: Implications for the delivery of educational and mental health services in schools. *School Psychology Review, 27*, 348-363.

Ebata, A., & Moos, R. (1994). Personal, situational, and contextual correlates of coping in adolescence. *Journal of Research on Adolescence, 4*, 99-125.

Gray, R. (1987). Adolescent response to the death of a parent. *Journal of Youth and Adolescence, 16*, 511-525.

Green, B. L., Grace, M., & Lindy, J. D. (1983). Levels of functional impairment following a civilian disaster: The Beverly Hills Supper Club fire. *Journal of Consulting and Clinical Psychology, 51*, 573-586.

Green B. L., Korol, M., Grace, M. C., Vary, M. G., Leonard, A. C., Gleser, G. C., & Smitson-Cohen, S. (1991). Children and disaster: Age, gender, and parental effects on PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 30*, 945-951.

Horowitz, M. J. (1986). Disaster stress studies: Conclusions. In J. H. Shore (Ed.), *Disaster stress studies: New methods and findings* (pp. 142-149). Washington, DC: American Psychiatric Press.

King, D. W., King, L. A., Foy, B. W., & Gudanowski, D. M. (1996). Prewar factors in combat-related posttraumatic stress disorder: Structural equation modeling with a national sample of female and male Vietnam veterans. *Journal of Consulting and Clinical Psychology, 64*, 520-531.

King, L. A., King, D. W., Fairbank, J. A., Keane, T. M., & Adams, G. A. (1998). Resilience-recovery factors in post-traumatic stress disorder among female and male Vietnam veterans: Hardiness, postwar social support, and additional stressful life events. *Journal of Personality and Social Psychology, 74*, 420-434.

Kinzie, J. D., Sack, W. H., Angell, R. H., Manson, S., & Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the American Academy of Child Psychiatry, 25*, 370-376.

Lewis, O. (1970). *A death in the Sanchez family*. New York: Vintage.

Luthar, S. S. (1991). Vulnerability and resilience: A study of high-risk adolescents. *Child Development, 62*, 600-616.

Luthar, S. S., & Zigler, E. (1991). Vulnerability and competence: A review of research on resilience in childhood. *American Journal of Orthopsychiatry, 61*, 6-22.

Lutzke, J. R., Ayers, T. S., Sandler, I. N., & Barr, A. (1997). Risks and interventions for the parentally bereaved child. In S. A. Wolchik & I. N Sandler (Eds.), Handbook of children's coping: *Linking theory and intervention* (pp. 215-244). New York: Plenum.

Lutzke, J. R., Li, S., Ayers, T., & Sandler, I. N. (1995, June). *Self-esteem and locus of control as mediators of the effects of bereavement stress on children's adjustment.* Poster presented at the Biennial Conference of the Society for Community Research and Action, Chicago, IL.

Lyons, J. A. (1991). Strategies for assessing the potential for positive adjustment following trauma. *Journal of Traumatic Stress*, 4, 93-111

Lystad, M. (1985). Special programs for children. In M. Lystad (Ed.), *Innovations in mental health services to disaster victims* (pp. 151-160). [DHHS Publication No. ADM 85-1390]. Rockville, MA: National Institute of Mental Health.

Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, 53, 205-220.

Matsakis, A. (1994). *Post-traumatic stress disorder: A complete treatment guide*. Oakland, CA: New Harbinger.

McFarlane, A. C. (1986). Long-term psychiatric morbidity after a natural disaster: Implications for disaster planners and emergency services. *Medical Journal of Australia, 145*, 561-563.

McFarlane, A. C. (1990). Vulnerability to posttraumatic stress disorder. In M. E. Wolf & A. D. Mosnaim (Eds.), *Posttraumatic stress disorder: Etiology, phenomenology, and treatment* (pp. 2-20). Washington, DC: American Psychiatric Press.

McFarlane, A. C., & De Girolamo, G. (1996). The nature of traumatic stressors and the epidemiology of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 129-153). New York: Guilford Press.

McFarlane, A. C., & Yehuda, R. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 155-181). New York: Guilford Press.

McIntosh, D., Cohen Silver, R., & Wortman, C. (1993). Religion's role in adjustment to a negative life event: Coping with the loss of a child. *Journal of Personality and Social Psychology*, 65, 812-821.

Milgram, N. A., Toubiana, Y. H., Klingman, A., Raviv, A., & Goldstein, R. (1988). Situational exposure and personal loss in children's acute and chronic stress reactions to a school bus disaster. *Journal of Traumatic Stress, 1*, 339-352.

Mitchell, J. T., & Everly, G. S. (1996). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers* (2nd ed., rev.). Ellicott City, MD: Chevron.

Nader, K., & Pynoos, R. (1993). School disaster: Planning and initial interventions. *Journal of Social Behavior and Personality*, 8, 1-22.

Nader, K., Pynoos, R., Fairbanks, L., & Frederick, C. (1990). Children's post-traumatic stress disorder reactions one year after a sniper attack at their school. *American Journal of Psychiatry, 147*, 1526-1530.

Newman, C. J. (1976). Children of disaster: Clinical observations at Buffalo Creek. *American Journal of Psychiatry*, 133, 306-312.

Norris, F. R., & Murrell, S. A. (1988). Prior experience as a moderator of disaster impact on anxiety symptoms in older adults. *American Journal of Community Psychology, 16*, 665-683.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Life threat and post traumatic stress in school-age children. *Archives of General Psychiatry, 44*, 1057-1063.

Sandler, I., Tein, J., & West, S. (1994). Coping, stress, and the psychological symptoms of children of divorce: A cross-sectional and longitudinal study. *Child Development*, 65, 1744-1763.

Sandler, I. N., Wolchik, S. A., MacKinnon, D., Ayers, T. S., & Roosa, M. W. (1997). Developing linkages between theory and intervention in stress and coping processes. In S. A. Wolchik & I. N. Sandler (Eds.), *Handbook of children's coping: Linking theory and intervention* (pp. 3-41). New York: Plenum.

Saylor, C. F. (1993). *Children and disasters*. New York: Plenum.

Schwarz, E. D., & Kowalski, J. M. (1991). Malignant memories: PTSD in children and adults after a school shooting. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30, 936-944.

Shore, J. H., Tatum, E. L., & Vollmer, W. M. (1986). Psychiatric reactions to disaster: The Mount St. Helens experience. *American Journal of Psychiatry, 143*, 590-595.

Shore, J. H., Tatum, E. L., & Vollmer, W. M. (1990). The Mount St. Helens' stress response syndrome. In J. H. Shore (Ed.) *Disaster stress studies: New methods and findings* (pp. 78-97). Washington, DC: American Psychiatric Press.

Silverman, P., & Worden, W. (1992). Children's reactions in the early months after the death of a parent. *American Journal of Orthopsychiatry*, 62, 93-104.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Newton, MA: Allyn and Bacon.

Tatum, E. L., Vollmer, W. M., & Shore, J. H. (1986). Relationship of perception and mediating variables to the psychiatric consequences of disaster. In J. H. Shore (Ed.), *Disaster stress studies: New methods and findings* (pp. 100-121). Washington, DC: American Psychiatric Press.

Terr, L. C. (1983). Chowchilla revisited: The effects of psychic trauma four years after a school bus kidnapping. *American Journal of Psychiatry, 140*, 1543-1555.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*, 10-20.

Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A study of resilient children*. New York: McGraw Hill.

20

危
機

Group Crisis Intervention[1]

Stephen E. Brock, Ph.D.
California State University, Sacramento

At approximately 11:40 AM on January 17, 1989, a heavily armed lone gunman walked onto the crowded primary playground of Cleveland Elementary School in Stockton, California. After setting his car on fire, the gunman began shooting. The 105 AK-47 assault rifle rounds fired in less than two minutes tore holes through concrete walls and penetrated metal playground equipment. The damage it did to almost three dozen young bodies was unspeakable. Before committing suicide, the gunman had killed five children and wounded 29 others and one teacher (Cox & Grieve, 1989).

The Stockton, California, schoolyard shooting was one of the most violent acts ever to have been committed on school grounds. Thus, it is not surprising that its impact on the entire school was immense. Virtually every Cleveland Elementary School student was in need of support and/or guidance. Although approximately 50 mental health professionals responded almost immediately to this disaster, there were many more students in need than could be assisted by one-on-one crisis intervention. Thus, as the first day after this tragedy dawned, my colleagues and I found ourselves assigned to provide support to entire classrooms.

Background and Development of Classroom Crisis Intervention

From my experiences following the Stockton schoolyard shooting, I developed an approach to working with large groups of students traumatized by a common crisis. Subsequently, as my crisis intervention training, research, experiences, and thinking evolved, I began to more formally conceptualize the group crisis intervention process that we first employed with the students of one intermediate-grade classroom at Cleveland Elementary School.

Initially identified as Classroom Crisis Counseling (Brock, 1996; Brock, Sandoval, & Lewis, 1996), this model's early development was influenced by Terr's (1992) discussion of mini-marathon groups. Subsequently, my training in Disaster Mental Health Services (American Red Cross, 1994), Critical Incident Stress Management (Mitchell & Everly, 1996a, 1996b), and participation in the National Community Crisis Response Team Regional Training Institute (Young, 1998) led to several significant modifications that are included in the current discussion.

The most obvious change was re-labeling the model as Group Crisis Intervention (GCI). This was done to help clarify that a team composed entirely of crisis counselors is not required to implement this type of intervention (Galante & Foa, 1986). Although mental health professionals will play a leadership role in GCI, it is not psychotherapy. GCI is best thought of as a form of psychological first aid.

As coordinator of a school crisis intervention team for the past 12 years, I have had numerous opportunities to use this model. Although it was designed for use following traumatic events (e.g., a school shooting, the witnessing of fatal traffic accidents, etc.), GCI has also been adapted for use in the management of normal grief reactions. While my experiences have suggested GCI to be effective, I hope the present discussion will stimulate empirical study. Future research suggestions are offered later in this chapter.

General GCI Issues and Procedures

Who should participate in GCI? Any group of students having experienced a common trauma can be brought together in a GCI. As a rule, GCI groupings are relatively homogeneous (Mitchell & Everly, 1996a; Weinberg, 1990; Wollman, 1993). Groups can be identified according to several logical categories, including classroom membership, age, grade, familiarity with victims, and/or degree of traumatic event exposure (Pitcher & Poland, 1992). However, following major schoolwide disasters GCI is perhaps best employed with naturally occurring classroom groupings of vicarious trauma victims (Everly, Boyle, & Lating, 1999). In my experience the connections already developed by classmates facilitate group sharing and support. It is, however, appropriate to hold separate sessions for those students from different classrooms that were most directly involved with the trauma. In addition, it may be necessary to exclude from GCI students who are displaying acute stress reactions (Johnson, 1993). This approach is not designed for severely disturbed youths, nor should it be considered a substitute for those in need of professional mental health assistance. Severely traumatized students, whose crisis reactions may interfere with GCI, will require individual crisis intervention from a mental health professional. In general, it is recommended that this approach be offered only to vicarious trauma victims, and not to individuals directly involved in or severely traumatized by a crisis. Students who are displaying signs of acute psychological distress and/or have a history of prior unresolved psychic trauma might need to be excluded from the GCI session (Neria & Solomon, 1999).

What is the optimal size of the GCI group? While some have suggested that this type of intervention can be offered to very large groups (Weinberg, 1990; Terr, 1992), I have found GCI to be most effective with classrooms ranging in size from 15 to 30 students. Similarly, Young (1998) suggests that 20 to 25 individuals is the ideal size for group crisis intervention. Combining classrooms and creating groups of more than 40 students is not recommended (Bell, 1995; Mitchell & Everly, 1996a). Large groups are likely to limit group sharing and interfere with the expression of feelings (Schonfeld, 1989).

When should GCI be offered? A common belief is that immediacy is important to the success of any crisis intervention. Justification for this belief includes observations that individuals in crisis are suggestible and motivated and that children are susceptible to developing cognitive distortions that may interfere with recovery (Pagliocca, Nickerson, & Williams, 2002). It must be acknowledged, however, that there is virtually no empirical research regarding the timing of group crisis interventions with school-aged youths. Thus, clinical judgment must be used in determining when to offer GCI.

From their observations and experiences working with emergency response personnel, Mitchell and Everly (1996a) recommend not initiating group crisis interventions until trauma survivors are psychologically ready to talk about the crisis. Mitchell and Everly suggest that this typically means waiting at least 24 hours before conducting a debriefing. At the same time, however, they recommend that group crisis intervention be offered no later than 72 hours following the trauma.

From my experience working with school-aged youths, I recommend that GCI be made a priority following traumatic events. If, following a crisis, a teacher begins the school day by following the normal routine (without mentioning the trauma) it suggests to students that the trauma was not a significant event, which may lessen students' willingness to share. Thus, if it is either impossible or inappropriate for GCI to be held right away, teachers or school officials should at least acknowledge the magnitude of the crisis and inform students as to when GCI will be offered. In addition, I recommend that, once GCI is initiated, crisis intervenors should minimize interruptions and breaks (Mitchell & Everly, 1996a; Terr, 1992; Wollman, 1993). Consistent with this recommendation, GCI should not be initiated at the end of a school day. Doing so interferes with the ability to identify and work with overtly upset and anxious students (Schonfeld, 1989).

Given these observations, it is suggested that GCI not be initiated until the start of the first full school day following resolution of the crisis event. This timing will help to ensure that participants are psychologically ready to talk about the crisis event and that there will be enough time to complete the entire process. In addition, it will give the GCI team a chance to prepare, including verifying facts and reviewing the GCI process with the classroom teacher and/or other co-facilitators. Finally, it is important to reiterate that there are no hard and fast rules regarding the optimal timing of crisis intervention and that clinical judgment is necessary.

Where should GCI be offered? Another assumption is that crisis interventions should be provided "close to the scene" of the crisis event. Although limited support for this practice may exist with experience with combat soldiers, generalizing such findings to school children may not be appropriate (Pagliocca, Nickerson, & Williams, 2002). Thus, here again, clinical judgment must be used when determining where to offer GCI. In my experience, providing GCI in the school environment, with its naturally occurring social supports, is optimal. In addition, it is recommended that GCI take place in the students' regular classroom (Schonfeld, 1989), and traditional counseling settings be avoided (Farrington, 1995). This way minimizes unnecessary labeling of students as patients (Klingman, 1987) and reinforces the normality of crisis reactions. This setting also provides structure and routine that is reassuring and facilitates GCI's group processes. Classroom rules will make it easier to progress through GCI steps. In addition, it is suggested that the normal desk arrangement be used. If the classroom is not available, GCI should take place in as accessible, comfortable, normal, and natural an environment as possible. It is important to ensure that tissues are accessible, water is available, and all students know where restroom facilities are located (Young, 1998).

Who are GCI facilitators? Group crisis intervention sessions require a team effort (Farrington, 1995; Mitchell & Everly, 1996a, 1996b; Young, 1998). Thus, it is recommended that two or more staff members facilitate GCI. Larger groups will require more facilitators. A ratio of one facilitator for every 10 students is recommended (Weinberg, 1990). Support for this recommendation is found in research suggesting that, as participant to facilitator ratio increases, participants share less of their feelings and reactions (Armstrong et al., 1998).

Ideally, at least one of the GCI facilitators will be familiar to the students. A team composed entirely of outside crisis intervenors suggests that the trauma was so overwhelming that school staff members are themselves unable to cope, which may unnecessarily increase feelings of hopelessness. In addition, students may be less willing to share reactions and feelings with strangers than with familiar adults. Conversely, the presence of familiar adults who are supportive and nonjudgmental has been reported to contribute to students' willingness to share (Kneisel & Richards, 1988). If familiar adults present themselves as being a part of the solution to trauma problems, they can foster greater optimism and make the situation appear less hopeless. In addition, familiar adults can introduce outsiders and validate that they have special knowledge that will help students (Kneisel & Richards, 1988; Mitchell & Everly, 1996a). Typically, having the classroom teacher be a GCI support-facilitator ensures the presence of a familiar adult. Alternatively, the school counselor or psychologist can fill this role (Weinberg, 1990).

What are GCI facilitator roles? Because GCI is a team effort, it is critical to consider facilitator roles before each session. First, a lead-facilitator needs to be identified. Typically, the leader is a crisis intervention team member who has experience and training working with trauma survivors (Farrington, 1995; Wollman, 1993) and is familiar with GCI. The lead-facilitator is responsible for directing progress through GCI. Another important leader activity is to ensure that the GCI team has accurate and current crisis facts.

Next, support-facilitators need to be identified. Typically, these individuals say little during the GCI session unless called upon by the lead-facilitator (Young, 1998). This is not to say that they are not active in the GCI process. These individuals assist the lead-facilitator in monitoring the group. Especially with large classrooms, it is difficult for one crisis intervenor to facilitate GCI and monitor individual reactions. Support-facilitators help identify students in need of further crisis intervention support and intervene with individuals who are unable to participate in GCI. For example, they can gently remove and talk individually to students who become hysterical. Young (1998) further suggests that additional support-facilitator roles may include providing emotional and practical support to the lead-facilitator, recording group responses on a chalkboard or flip chart, and taking over the group if for some reason the lead-facilitator is unable to continue. Finally, support-facilitators are responsible for following, and ensuring the safety of, students who unexpectedly leave the classroom (Mitchell & Everly, 1996a; Weinberg, 1990; Young, 1998).

What is the role of the teacher? In most situations, crisis teams do not include the teacher(s) of the classroom(s) affected by the trauma. However, intervenors must be sensitive to the needs and desires of the teacher whose classroom they have entered. Doing so helps to ensure that the intervention is well received. As mentioned, insofar as possible, it is recommended that the teacher take an active role in GCI. This recommendation comes from the observation that collaboration is facilitated if crisis intervenors do not act as "the experts" but strive to involve the teacher in planning and implementing the classroom session (Blom, Etkind, & Carr, 1991). Ideally, the teacher will help to facilitate GCI. In some rare instances, the teacher may even lead the session. All lead-facilitators, however, should have training in group counseling (Allan & Nairne, 1984), experience working with psychological trauma victims (Nader, 2002), and be familiar with GCI. Alternatively, when the teacher is having significant difficulty coping with the crisis, outside crisis intervenors will need to take responsibility for GCI (Klingman, 1988). It is important for the crisis team to recognize that crises affect everyone differently and to establish an environment that makes it easy for teachers to acknowledge their limitations and ask for help.

The need for follow-up interventions. It is important to acknowledge that single-session group crisis interventions are likely insufficient for high-risk trauma survivors (e.g., those with poor pretrauma mental health; Larsson, Michel, & Lundin, 2000). Furthermore, among acute trauma victims (e.g., victims of acute burns, accidents requiring hospitalization, violent crime), some research suggests that single-session (or "one-off") crisis intervention (or debriefing) has limited benefit and may be potentially harmful (Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000; Rose, Brewin, Andrews, & Kirk, 1999). Finally, group approaches do not allow for the in-depth individual explorations that individual sessions provide (Nader, in press; Yule, 1998). Thus, it is important to remember that GCI is considered a form of psychological first aid. As such, it should not be viewed as a sufficient intervention for all traumatized students. Just as with medical first aid, more severe injuries will require more involved treatment (i.e., professional mental health intervention). In other words, for the more severely traumatized student, GCI will only be the first step in a treatment process. In such circumstances, GCI will be an intervention that helps to minimize harm until more sophisticated treatments can be accessed. (This issue is discussed later in this chapter in Post-GCI Activities.) At the same time, it is possible that, for less severe traumatization, GCI alone will be a beneficial intervention (Deahl et al., 2000).

GCI contraindications. In my experience GCI has been effective in a variety of situations. However, Johnson (1993) indicates that group crisis intervention approaches should be avoided under the following circumstances: (a) when the class has a history of being hurtful, divisive, and/or not supportive; (b) when student needs, relative to the trauma, are polarized (e.g., some students are deeply affected while others are untouched or find the crisis beneficial); and (c) when the traumatic event is politicized (e.g., gang membership had a role in the trauma). In addition, Nader (2002) has pointed out that courtroom credibility may be lost because of group influences. Thus, students who are prospective witnesses might need to be excluded from GCI sessions. Finally, it has been suggested that students who were directly exposed to the crisis, who were physically injured, who have preexisting problems, or who lack family support, should be offered individual crisis intervention (Yule, 1998).

The GCI Model

GCI has six steps: (a) introduction, (b) providing facts and dispelling rumors, (c) sharing stories, (d) sharing reactions, (e) empowerment, and (f) closing. Table 1 provides a summary of GCI. This procedure is similar to Allan and Nairne's (1984) Class Discussion Model. It helps students to understand the trauma, express thoughts and feelings, and identify/learn coping behaviors.

As with other forms of group crisis intervention, GCI is ideally completed in one session lasting approximately two to three hours (American Red Cross, 1994; Terr, 1992; Young, 1998). However, the length of GCI must be tailored to the developmental level of the classroom (i.e., older students will be able to participate in sessions for longer uninterrupted periods). For example, Johnson (1993) suggests that elementary-age students can at most be expected to participate in sessions lasting up to one hour. Thus, especially when working with younger children, it will be necessary to take restroom and recess breaks. However, once students have begun to share trauma experiences (sharing stories), breaks should be avoided until after the group has reviewed activities designed to help manage trauma reactions (empowerment; Mitchell & Everly, 1996a). Although it may be difficult to complete GCI in one uninterrupted session, it is recommended that all six steps be completed during the same school day.

Introduction. As with other forms of group crisis intervention, GCI begins with an introduction (American Red Cross, 1994; Mitchell and Everly, 1996a, Young, 1998). This step, which lasts 10 to 15 minutes, identifies GCI support-facilitators and the group leader. As mentioned, it is best if one or more of the GCI facilitators are

Table 1

Group Crisis Intervention (GCI) Summary

GCI Step	Facilitative Statements	Goal(s)	Goal Attainment Signs
Introduction	*I'm sorry this happened to your (our) school. When bad things like this happen, it is helpful to talk about it. So, we are going to spend some time today talking. From our discussion we will have a better understanding of what happened, how it has affected us, and what we can do to help each other cope.*	• Explain GCI purpose. • Identify facilitators. • Review GCI steps. • Review rules.	• Questions about GCI stop.
Providing Facts and Dispelling Rumors	*We have experienced an event that was so unusual we might find it hard to understand. I would like to share with you what we know about this tragedy. Feel free to ask questions. It's important that you understand what happened.*	• Assist students to come to a reality-based understanding of the event.	• Questions about the traumatic event stop.
Sharing Stories	*Each person who gets through an event, such as the one we have just experienced, has a story. We are going to tell as many of these stories as we can today. Who wants to start?*(Terr, 1992, p. 79).	• Get students to talk about their experiences. • Help students feel less alone and more connected to classmates.	• Everyone has had a chance to share crisis stories.
Sharing Reactions	*Following a trauma, such as the one we've just experienced, it is not unusual for people to feel and behave differently for a while. Some common reactions are ... These are normal reactions to abnormal circumstances. Who has had some of these reactions?*	• Get students to talk about trauma reactions. • Help students feel more connected to classmates. • Normalize trauma reactions.	• Everyone has had a chance to share trauma reactions.
Empowerment	*Traumatic events can make us feel helpless. I would like to see us take action or make plans to repair trauma related damage or prevent trauma reoccurrence.*	• Help students regain a sense of control over their lives.	• Concrete action is taken or planned.
Closing	*What can we do to begin to place this event behind us and move on with our lives?*	• Help students begin to think about placing the trauma behind them.	• Completion of activities that enable students to begin the process of saying good-bye to that which was lost.

BEST COPY AVAILABLE

familiar to the students. A facilitator familiar to the students should introduce unfamiliar facilitators to the class.

After completing introductions and identifying the group leader, the leader explains the purpose of the session. In doing so, it is important to be positive and offer the expectation that GCI is effective. The leader should convey that, with talk and time, most students will cope with the trauma. Although the leader states that students will be working together to understand the trauma, he or she should acknowledge that facilitators have special information to share. Then, the leader briefly describes each GCI step.

Next, the leader should review GCI rules. Students are reminded they are still in school and that regular classroom rules are in effect. Perhaps most importantly, students are told that they are not allowed to leave the room without permission. However, students are told that active participation is voluntary. Additional group process rules may also need to be established. For example, it is essential to discuss the issue of confidentiality. While students should be given permission to discuss whatever they want, it will be important to set limits regarding the fact that verbal and/or physical violence or abuse will not be tolerated (Young, 1998).

I have found it helpful to allow students to assist with setting group rules. Doing so helps to establish an atmosphere in which students are regarded as capable problem solvers. Examples of group process rules include speaking one at a time, encouraging and supporting the efforts of others, and not allowing put-downs. In concluding the introduction, the leader should also mention that facilitators will be available to the class after the GCI session is completed.

Providing facts and dispelling rumors. Unique to the GCI technique is a specific step designed to provide students with facts about the trauma and to dispel rumors. This step lasts approximately 30 minutes. Because students, particularly younger children, have typically had little experience with traumatic events, they will be frightened and confused. In addition, because of their developmental level they may be more susceptible to distortions of the event and its cause. Thus, GCI begins by making certain that students have a fact-based understanding of the trauma.

When providing crisis facts it is important to be sensitive to developmental levels (Lord, 1990; Mitchell & Everly, 1996b). For example, with intermediate-grade students, carefully selected, well-written newspaper articles about the trauma may be helpful to clarify what happened (Klingman, 1987; Terr, 1989). However, with younger students, this would be an inappropriate strategy. Younger students should receive more simplistic descriptions of the event. It is important to remember that the novelty of the situation may make it difficult for students to understand the facts, and facilitators should be prepared to repeat them frequently (Lord, 1990).

It is especially important to dispell rumors because they are typically more frightening than reality (Blom et al., 1991). For example, following the Stockton schoolyard shooting there was a persistent rumor that only one of two gunmen had been identified. This rumor was started because the lone gunman, who had assaulted the playground and then committed suicide, had fired from two separate locations (Armstrong, 1990). The mistaken belief that a gunman was still at large was frightening for students. Such mistaken information can be very distracting and makes coping more difficult. Thus, making sure students have a reality-based understanding of the trauma is important to crisis resolution (Lord, 1990).

Sharing stories. When questions about trauma facts and rumors stop, the classroom is ready to continue. The sharing of student experiences during the event is the next step, which may last from 30 to 60 minutes (American Red Cross, 1994; Galante & Foa, 1986; Mitchell & Everly, 1996a; Terr, 1992; Young, 1998).

While keeping in mind that active participation is voluntary, in smaller classrooms, facilitators will want to move around the GCI group and give each student the opportunity to share. In larger groups (i.e., 30 students) facilitators may not have enough time to do this and may simply ask for volunteers. Specific questions to facilitate this step, suggested by Young (1998), include the following:

- Where were you when it happened?
- Who were you with?
- What did you see, hear, smell, taste, or touch at the time?
- What did you do?
- How did you react?

Facilitators should validate all experiences and reactions and common themes identified (Terr, 1992; Young, 1998). This validation will help students feel more connected to each other and less alone because of their common experiences. It will give students the added strength needed to face and work through the trauma.

Besides asking students to verbalize their experiences, it is also helpful to allow them to recount experiences and reactions in other ways. Art and other creative activities can be a helpful method of expression (Farrell & Joseph, 1991; Johnson, 1993; Klingman, Koenigsfeld, & Markman, 1987; Terr, 1992), especially for younger students who may have difficulty verbalizing what has happened. These activities are also a way to break up a GCI session and may be especially helpful for students who have difficulty sitting still. Johnson (1993), for example, suggests that activities may comprise a majority of the session with elementary-age students. Petersen and Straub (1992) offer an excellent compilation of activities that may prove helpful in a GCI session.

Sharing reactions. Once most, if not all, of the group has had a chance to tell their crisis stories, the next step is to examine crisis reactions. This GCI component is also a part of other group crisis intervention techniques (American Red Cross, 1994; Mitchell & Everly, 1996a; Terr, 1992; Young, 1998). Terr (1992) recommends the following approach to this step: (a) stating common reactions, (b) asking those who have experienced each reaction to raise their hand, (c) asking for individual examples, (d) summarizing comments about reactions experienced, and (e) anticipating reactions that may arise in the future. This step lasts approximately 30 minutes.

Common initial psychological and behavioral symptoms displayed by children following traumatic events include sleep disorders, bad dreams, persistent thoughts of the trauma, belief that another trauma will occur, conduct disturbances, hyper-alertness, avoidance of trauma reminders, and somatic reactions. In younger children, regression to enuresis, thumb-sucking, and more dependent behavior may also be seen (Frederick, 1985). These reactions can be very unsettling, and it is not uncommon for survivors to fear that they are going crazy. Group sharing and facilitator anticipation of trauma reactions help normalize these sometimes frightening symptoms (Armstrong, Lund, McWright & Tichenor, 1995; Mitchell & Everly, 1996a; Terr, 1992).

As students share feelings and reactions, facilitators should not be surprised if some students begin to cry. Students should be told that this reaction is normal and, as long as the classroom is not too distracted by these tears, crying students should remain in the classroom (Lord, 1990). However, students who become hysterical may need to be removed. Their presence can be so distracting that the GCI process will stop (Mitchell & Everly, 1996a).

During this step, GCI facilitators should explicitly state that initial trauma reactions are normal responses to abnormal circumstances (Lord, 1990). Facilitators should also let students know that, with time, for most people, these reactions will go away. However, students should also be informed of what to do if they feel that they are unable to manage crisis reactions. This is a natural time to ensure that students are aware of self-referral procedures for obtaining one-on-one crisis intervention. Facilitators should assure students that, if used early, crisis intervention and therapy can reduce symptoms quickly and with a minimum of pain. "If a traumatic response does not have the chance to become entrenched, it will become only a small scar on a very large life" (Terr, 1992, p. 32).

As this step ends it is appropriate to assist students to predict what they might expect in the future. Specific questions to facilitate such prediction, suggested by Young (1998), include the following:

- What do you think will happen next?
- Will you, your friends, and family continue to be affected?
- What concerns you?

With an understanding of how the crisis event has affected them, and what some potential future concerns might be, students will be ready to engage in a discussion of how to cope with the trauma.

Empowerment. After students have shared trauma experiences and effects, the next step is for students to begin to participate in activities that help them regain a sense of control. Again, aspects of this step can be found in other group crisis intervention strategies (American Red Cross, 1994; Mitchell & Everly, 1996a; Terr, 1992; Young, 1998). During this step students learn that, no matter how impossible circumstances may appear, there are things they can do to improve their situation (Allan & Nairne, 1984). An important goal of this step is the identification of coping strategies (Armstrong et al., 1995). This step may last up to 60 minutes.

A recommended activity for beginning this step is discussion of what students have done in the past to cope with problems (Young, 1998). As these previously developed coping strategies are identified, the facilitator should reinforce those that are adaptive (e.g., "Yes, talking to friends and family is a helpful way to cope with problems"). If maladaptive strategies are proposed, the facilitator will need to offer alternatives (e.g., "No, drinking is not an effective way to deal with a problem, but exercise is a great way to deal with stress").

Because GCI is a form of crisis intervention, not psychotherapy, facilitators can be very directive during this step. However, students should be as active as possible in identifying coping strategies. Encouraging this independent thinking will reinforce the idea that students are regaining control over what is happening. During this step, it is important that basic stress management techniques be presented, specifically, the importance of getting needed sleep, food, exercise, and talking to friends and family (Mitchell & Everly, 1996a; Weinberg, 1990). Additional options for this step include having students work together on developing strategies to gradually desensitize each other to trauma-related fears (Terr, 1992) and teaching them how to reply to intrusive thoughts and images (Brown, 1996). Through this discussion, students will begin to see a variety of options for coping with trauma and trauma reactions.

Another activity that may be appropriate following certain types of crises is to ask students to brainstorm strategies to prevent reoccurrence of the traumatic event. During this initial brainstorming, student ideas and suggestions are recorded and validated as ways of regaining control over circumstances. Once all ideas have been presented, facilitators can help guide students toward an evaluation of each suggestion. Especially helpful are suggestions that allow for immediate concrete action. For example, following a schoolyard shooting one classroom decided to write letters to government officials regarding the need for gun control. Of course, this approach to empowerment must be used carefully. Caution must be exercised to ensure that the ideas and suggestions generated do not create feelings of guilt. For example, the crisis intervenor would want to avoid reinforcing ideas that might lead students to believe they could or should have done something to prevent the trauma (e.g., we could prevent schoolyard shootings if students agree to attack gunmen). If these beliefs are validated it can foster survivor guilt that makes crisis resolution more difficult.

In closing this step, Terr (1992) suggests that facilitators review tales of heroism and survival. They should praise the courage of students in facing the trauma and looking ahead toward the future.

Closing. The final step in GCI is for students to engage in activities that start to bring a sense of closure to the trauma. This step may last up to 30 minutes. The development of memorials is a natural activity after trauma resulting in death. A variety of creative projects can serve as memorials. Ideally, these will be projects that all students can help to develop. It is important to mention that all memorial projects should be carefully screened before they are delivered to trauma victims and/or their families. Because of their own anxiety and beliefs, students may generate messages that are potentially hurtful. These messages should be screened out (Brock et al., 1996; Lord, 1990). Students who create such messages need to be discretely counseled regarding what makes an appropriate memorial and given another opportunity to participate in the project. In addition, if time is a problem this step may only involve the planning of memorial projects. Completion of these projects can be reserved for another day.

Other closing activity options include preparation for attending or participating in funerals (Lord, 1990; Mitchell & Everly, 1996b) and the writing of get-well cards and letters to victims. If the class has experienced the death of a classmate or teacher, this step should include discussion of what to do with the deceased's desk and belongings (Lord, 1990).

In concluding GCI, facilitators should answer any remaining questions. The GCI is then summarized and closing comments made. If time permits, students may be asked to share what they have learned from the GCI session and what empowerment ideas they are committed to implementing (Allan & Nairne, 1984). In their closing comments facilitators should remind students that they are experiencing normal reactions to abnormal circumstances. Facilitators should acknowledge that, for some students, it might be some time before they are truly able to place the crisis event in their past and move on with their lives, and that, for some students, their lives might never be the same. At the same time, however, facilitators should be positive about the future and remind students that, while memories will remain, with time and talk, the associated pain will lessen and symptoms will typically disappear. Finally, the facilitators should reassure students that additional crisis intervention services are available, if needed, and reiterate self-referral procedures.

Post-GCI Activities

Following the GCI session, students' caregivers need to be informed about the actions they can take to facilitate continued discussion and help students cope. These recommendations, which should be provided to the families of all GCI participants, include the following:

- Listen to and spend time with your child.
- Offer to talk about the trauma.
- Reassure your child that he or she is safe.
- Offer assistance with everyday tasks and chores.
- Respect your child's privacy.
- Do not take anger or other reactions personally (Mitchell & Everly, 1996b).

After GCI has ended, at least one, but preferably all, of the facilitators should remain with the students (Mitchell & Everly, 1996a). At the very least, a facilitator should be available to students throughout the remainder of the school day, to allow students additional opportunities to seek out support and to have questions answered. It will also give facilitators additional opportunities to assess how individual students are coping.

Finally, as soon as possible after GCI, facilitators should debrief the session. This debriefing typically occurs at the end of the school day and serves two important purposes. First, it allows discussion of student reactions and decisions regarding who will need one-on-one crisis intervention (Neria & Solomon, 1999). Table 2, on page 398, provides a list of indicators suggesting the need for such support.[2] Second, facilitators should focus on their own reactions and coping. In particular, special attention needs to be directed toward the teacher (Lord, 1990). If needed, crisis intervention services should be made available to the teacher and other GCI team members. Ideally, these services are provided by a crisis team member, trained in psychological debriefing (e.g., Mitchell & Everly, 1996b), who was not a part of the initial crisis intervention response.

Advantages of GCI

Practical advantages. Group approaches to crisis intervention have previously been identified as efficient and cost-effective (Courchaine & Dowd, 1994; Gelsomino & Mackey, 1988). This observation highlights the most obvious advantage of GCI—it allows large numbers of trauma survivors to be seen at one time. Given that situational crises have the potential to affect many more students than most school mental health resources can handle (Weinberg, 1990), this is an especially important issue for school crisis intervention teams.

Table 2

Indicators of the Need for a One-on-One Crisis Intervention Referral

1. Suicidal ideation or plans.
2. Inability to control emotional reactions and arousal level.
3. Disassociation and/or bizarre behavior.
4. Excessive self-blame or intropunitive anger.
5. Absence of emotional reactions in those who were close to trauma victims and/or who witnessed the traumatic event.
6. Poor pretrauma mental health (i.e., emotionally disturbed).
7. Physically injured during the crisis event.

Note
From Larsson et al. (2000), McFarlane and Yehuda (1996), and Weinberg (1990).

Treatment advantages. GCI also takes advantage of the demonstrated value of posttrauma group treatment models (Chemtob, Thomas, Law, & Cremniter, 1997; Everly et al., 1999). More specifically, it has been suggested that active contact and dialogue among groups of trauma survivors are important to the healing process (Gelsomino & Mackey, 1988). In addition, group interventions have been found to reduce anxiety, improve self-efficacy, enhance group cohesion (Shalev, Peri, Rogel-Fuchs, Ursano, & Marlowe, 1998), and play a role in reducing alcohol misuse (Deahl et al., 2000).

Specific GCI treatment advantages include my observation that it helps students feel less alone and more connected to their classmates because of their common experience. GCI's group processes allow students to observe that they have shared a common experience and are having similar reactions. In addition to building group cohesion (Shalev et al., 1998), this commonality may help to give students the emotional strength needed to face and cope with a trauma. In addition, by promoting the idea that trauma responses are normal, GCI may help students regain a sense of hope and optimism, which in turn helps them to view their reactions as manageable (Gelsomino & Mackey, 1988). The final advantage of GCI is that it is an efficient way to help identify students in need of one-on-one crisis intervention. This is important because it will not always be immediately apparent who is most significantly affected by a trauma. (See Chapter 19 for discussion on identifying psychological trauma victims.)

Research Suggestions

My observations suggest that GCI is effective. However, while previous research has demonstrated the effectiveness of this type of crisis intervention with adults (Mitchell & Everly, 1996a) and multiple-session interventions with children (Galante & Foa, 1986), to my knowledge, no one has conducted a controlled, empirical study of this approach with children. Thus, research in this area is critically needed (Kutash & Rivera, 1996; Rose & Bisson, 1998). Specifically, a methodology should be employed that will help to assess possible relationships between GCI participation and measures of posttraumatic stress and school functioning (e.g., school attendance rates, group achievement test scores, discipline records, etc.). If available, pretrauma baseline data (especially for measures of school functioning) should be considered. Additional assessment should take place immediately before GCI, immediately after GCI, two days after the traumatic event (the duration required for an acute stress disorder diagnosis), one month after the event (the duration required for an acute posttraumatic stress disorder diagnosis), and finally three months after the event (the duration required for a chronic posttraumatic stress disorder diagnosis). Experimental or quasi-experimental research designs should be employed (Kutash & Rivera, 1996). For example, individuals or classrooms could be randomly assigned to a GCI treatment group, a no-treatment group, and/or an alternative crisis intervention treatment group. When comparing treatment conditions, it will be important to control for variables, such as degree of exposure to the traumatic event, and other risk factors, such as familiarity with crisis victims and preexisting psychopathology, that are known to increase vulnerability to a psychological trauma.

References

Allan, J. A. B., & Nairne, J. (1984). *Class discussions for teachers and counsellors in elementary school.* Toronto, Canada: University of Toronto.

American Red Cross. (1994). *Disaster Mental Health Services I: Participant's Attachments* (Attachment 12, p. 43). Washington, DC: Author.

Armstrong, K. R., Lund, P. E., McWright, L. T., & Tichenor, V. (1995). Multiple stress debriefing and the American Red Cross: The East Bay Hills fire experience. *Social Work, 40,* 83-90.

Armstrong, K. R., Zatzick, D., Metzler, T., Weiss, D. S., Marmar, C. R., Garma, S., Ronfeldt, H., & Roepke, L. (1998). Debriefing of American Red Cross personnel: Pilot study on participants' evaluations and case examples from the 1994 Los Angeles earthquake relief operation. *Social Work in Health Care, 27,* 33-50.

Armstrong, M. (1990, April). Emotional reactions to Stockton. In F. Busher (Chair), *Tragedy in Stockton school yard.* Symposium conducted at the meeting of the National Association of School Psychologists, San Francisco, CA.

Bell, J. L. (1995). Traumatic event debriefing: Service delivery designs and the role of social work. *Social Work, 40,* 36-43.

Bisson, J. I., Jenkins, P. L., Alexander, J., & Bannister, C. (1997). Randomized control trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry, 171,* 78-81.

Blom, G. E., Etkind, S. L., & Carr, W. J. (1991). Psychological intervention after child and adolescent disasters in the community. *Child Psychiatry and Human Development, 21,* 257-266.

Brock, S. E. (1998). Helping classrooms cope with traumatic events. *Professional School Counseling, 2,* 110-116.

Brock, S. E. (1996, Summer). Classroom crisis counseling. NASP *Communiqué, 24*(9), 4-6.

Brock, S. E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools: A manual for building crisis response teams.* Brandon, VT: Clinical Psychology Publishing Company.

Brown, D. (1996). Counseling the victims of violence who develop posttraumatic stress disorder. *Elementary School Guidance and Counseling, 30,* 218-227.

Chemtob, C. M., Thomas, S., Law, W., & Cremniter, D. (1997). Postdisaster psychosocial intervention: A field study of the impact of debriefing on psychological distress. *American Journal of Psychiatry, 154,* 415-417.

Courchaine, K. E., & Dowd, E. T. (1994). Group approaches. In F. M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (pp. 221-237). New York: Guilford Press.

Cox, J. D., & Grieve, T. (1989, January 19). Schoolyard slaughter—5 killed, 30 injured. Stockton rampage ends with suicide. *Sacramento Bee,* p. 1.

Deahl, M., Srinivsan, M., Jones, N., Thomas, J., Neblett, D., & Jolly, A. (2000). Preventing psychological trauma in soldiers: The role of operational stress training and psychological debriefing. *British Journal of Medical Psychology, 73,* 77-85.

Everly, G. S., Boyle, S. H., & Lating, J. M. (1999). The effectiveness of psychological debriefing with vicarious trauma: A meta-analysis. *Stress Medicine, 15*, 229-233.

Farrell, J., & Joseph, A. (1991). Expressive therapies in a crisis intervention service. *Arts in Psychotherapy, 18*, 131-137.

Farrington, A. (1995). Suicide and psychological debriefing. *British Journal of Nursing, 4*, 209-211.

Frederick, C. J. (1985). Children traumatized by catastrophic situations. In S. Eth and R. S. Pynoos (Eds.), *Post-traumatic stress disorder in children* (pp. 71-100). Washington, DC: American Psychiatric Association Press.

Galante, R., & Foa, D. (1986). An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. *Journal of the American Academy of Child Psychiatry, 25*, 357-363.

Gelsomino, J., & Mackey, P. W. (1988). Clinical interventions in emergencies: War-related events. In M. Lystad (Ed.), *Mental health response to mass emergencies: Theory and practice* (pp. 221-238). New York: Brunner/Mazel.

Johnson, K. (1993). *School crisis management: A hands-on guide to training crisis response teams*. Alameda, CA: Hunter House.

Kneisel, P. J., & Richards, G. P. (1988). Crisis intervention after the suicide of a teacher. *Professional Psychology: Research and Practice, 19*, 165-169.

Klingman, A. (1987). A school-based emergency crisis intervention in a mass school disaster. *Professional Psychology: Research and Practice, 18*, 604-612.

Klingman, A. (1988). School community in disaster: Planning for intervention. *Journal of Community Psychology, 16*, 205-216.

Klingman, A., Koenigsfeld, A., & Markman, D. (1987). Art activity with children following a disaster: A prevention-oriented crisis intervention modality. *Arts in Psychotherapy, 14*, 153-166.

Kutash, K., & Rivera, V. R. (1996). *What works in children's mental health services: Uncovering answers to critical questions*. Baltimore: Brooks.

Larsson, G., Michel, P., & Lundin, T. (2000). Systematic assessment of mental health following various types of posttrauma support. *Military Psychology, 12*, 121-135.

Lord, J. H. (1990). *Death at school: A guide for teachers, school nurses, counselors, and administrators*. Dallas, TX: Mothers Against Drunk Driving.

Mayou, R. A., Ehlers, A., & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims: Three-year follow-up of a randomized controlled trail. *British Journal of Psychiatry, 176*, 589-593.

McFarlane, A. C., & Yehuda, R. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 155-181). New York: Guilford Press.

Mitchell, J. T., & Everly, G. S. (1996a). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers* (2nd ed., rev.). Ellicott City, MD: Chevron.

Mitchell, J. T., & Everly, G. S. (1996b). *Critical incident stress management: The basic course workbook*. Ellicott City, MD: International Critical Incident Stress Foundation.

Nader, K. (200). Innovative treatment methods for psychological trauma. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson, *Best practices in school crisis prevention and intervention* (pp. 675-704). Bethesda, MD: National Association of School Psychologists.

Neria, Y., & Solomon, Z. (1999). Prevention of posttraumatic reactions: Debriefing and frontline treatment. In P. A. Saigh & J. D. Bremmer (Eds.), *Posttraumatic Stress Disorder: A comprehensive text* (pp. 309-326). Boston: Allyn and Bacon.

Pagliocca, P., Nickerson, A. B., & Williams, S. H. (2002). Research and evaluation directions in crisis intervention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson, *Best practices in school crisis prevention and intervention* (pp. 771-790). Bethesda, MD: National Association of School Psychologists.

Petersen, S., & Straub, R. L. (1992). *School crisis survival guide: Management techniques and materials for counselors and administrators*. West Nyack, NY: Center for Applied Research in Education.

Pitcher, G. D., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.

Rose, S., & Bisson, J. (1998). Brief early psychological interventions following traumas: A systematic review of the literature. *Journal of Traumatic Stress, 11*, 697-710.

Rose, S., Brewin, C. R., Andrews, B., & Kirk, M. (1999). A randomized controlled trial of individual psychological debriefing for victims of violent crime. *Psychological Medicine, 29*, 793-799.

Schonfeld, D. J. (1989). Crisis intervention bereavement support: A model of intervention in the children's school. *Clinical Pediatrics, 28*, 27-33.

Shalev, A. Y., Peri, T., Rogel-Fuchs, Y., Ursano, R. J., & Marlowe, D. (1998). Historical group debriefing after combat exposure. *Military Medicine, 163*, 494-498.

Terr, L. C. (1989). Treating psychic trauma in children: A preliminary discussion. *Journal of Traumatic Stress, 2*, 3-20.

Terr, L. C. (1992). Mini-marathon groups: Psychological "first aid" following disasters. *Bulletin of the Menniger Clinic, 56*, 76-86.

Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions. *Professional Psychology Research and Practice, 21*, 271-278.

Wollman, D. (1993). Critical incident stress debriefing and crisis groups: A review of the literature. *Group, 17*, 70-83.

Young, M. A. (1998). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

Yule, W. (1998). Posttraumatic Stress Disorder in children and its treatment. In T. W. Miller (Ed.), *Children of trauma: Stressful life events and their effects on children and adolescents* (pp. 219-244). Madison, CT: International University Press.

Endnotes

[1] Adapted from Brock, S. E. (1998). Helping classrooms cope with traumatic events. *Professional School Counseling*, 2, 110-116.

[2] If a student is known to demonstrate the indicators listed in Table 2, on page 398, before a GCI session, he or she should be immediately referred to a mental health professional for individual assistance. It is inappropriate to include these students in GCI.

21

危機

Individual Crisis Intervention

Kathleen Nader, D.S.W.
Two Suns (Cedar Park, TX)

Paulette Muni, Ph.D.
Private Practice (Goshen, NY)

Surviving a traumatic event often results in significant and multiple long-term consequences (Table 1, on page 406). A history of prior traumas and/or trauma symptoms has been found among individuals who commit school violence, who are on death row, who are emotionally disturbed, and who have personality disorders or engage in repetitive self-destructive behaviors. Given these possible long-term results, it is crucial that professionals working with youth understand trauma's risk factors and warning signs and become knowledgeable regarding immediate and ongoing trauma interventions. This chapter provides a framework for organizing an effective initial intervention program for the aftermath of a traumatic experience. It addresses the individual needs of students, parents, and school staff when a trauma has occurred on or off campus. Individual crisis intervention includes: (a) anticipating and administratively preparing for crises in ways that minimize trauma and facilitate recovery; (b) interventions during and immediately following the event; (c) methods of triage and debriefing that assist coping and recovery; and (d) preparation for long-term interventions, if needed. These issues and specific posttraumatic behaviors and therapeutic approaches are discussed below.

Preparation for Initial Crisis Intervention

Pretrauma efforts by administrators and teachers can facilitate posttrauma interventions. Preparation includes knowledge building, practice and assessment, and possible rearrangement of the environment. A well-prepared staff can reduce the adverse effects of trauma.

Administrators

For effective intervention to occur, the existing lines of administrative power within a school system must be recognized and utilized. Superintendents should engage in

Table 1

Possible Results of Unresolved Trauma

Results	Examples
Influenced Life	Reasonably normal life influenced by experience (e.g., may affect expectations, attitudes, interactions, choices, and behaviors; may create vulnerabilities).
Changes in Personal Traits	Changes in cognitive ability, morality, and/or normal mood; reduced confidence; inhibitions; increased aggression.
Disturbances in Inter-Personal Functioning	Choosing friends who have been or feel victimized; loss of friends; irritability/bullying; withdrawal.
Cognitive Dysfunction	Memory and concentration problems; inhibited imagination; confusion; delayed processing of information.
Mental Health Disturbances	Chronic or complicated PTSD; substance-related disorders; conduct, mood, anxiety, somatoform, eating, sleep, impulse control, personality, and/or dissociative disorders.
Attempts at Numbing Emotions	A style of confusion, self-distraction or distracting others; substance or medication abuse; varying levels of dissociation.
Compulsive Repetition of Traumatic Behaviors and Sequences	Dangerous risk taking; reenactments of aspects of the event (such as promiscuity or prostitution after molestation, aggressive acts when dressed like an assailant, feeling choked and exhausted any time adrenalin increases); provoking attacks.
Self-Punishment or Warding Off	Provoking attacks; poor self-care; repeated poor choices with problematic results; self-isolation; self-mutilation.
Somatic Complaints or Ill Health	Aches and pains such as stomachaches, body aches, headaches; deficient immune response.

Note

Reprinted from Nader (2001).

BEST COPY AVAILABLE

disaster planning that (a) identifies rescue and recovery personnel, (b) community leaders who support the school system, (c) funding sources for increased needs and interventions, (d) and personnel who would be able to assist in recovery operations (such as reputable construction companies, skilled consultants, a mental health team, additional teaching assistants, and support staff). School principals should be aware of teachers and parents in each school who are respected and who have leadership qualities and problem-solving skills. Understanding the cultures in each school and knowing cultural leaders can enhance a timely initial intervention process and reduce stress. All administrators should become educated in the nature of the traumatic response and its course. An understanding of childhood traumatic reactions, including anniversary reactions, reactivity to traumatic reminders, the need for appropriate memorials, and the need to express feelings about what has happened will prepare administrators to play a helpful role on behalf of their injured students. It is essential to be prepared to address the long-term reactions of students over time. Administrators must realize that their response to the injured will set the course for their communities. Overtly or covertly requesting silence or the premature appearance of recovery only perpetuates the emotional consequences of trauma. Kindness is a part of prevention and intervention. After a school or community trauma, it is in the hands of school administrators, consultants, and the mental health team to rally the entire community and school district around the injured.

Teachers and Staff

A variety of preparations may increase a sense of safety and competency, diminish injury and traumatic reactions, and assist teachers and staff to intervene during and immediately after a crisis (Nader, 1999; see Table 2, on page 408). Preparation differs for each disaster. While potential earthquakes or tornadoes necessitate removal of items that may fall or fly and injure students, shootings or hostage-takings may require preparing or quickly rearranging the environment (Nader & Mello, in press). Removal from the danger zone during or after the event necessitates knowing alternative communication methods, safe exits, and safe locations. Exit and classroom drills that prepare but do not overly frighten students for the possibility of these events are important. Staff sessions that envision possible scenarios with appropriate reactions and teach self-defense methods may prevent multiple murders (Nader & Mello, in press). Some schools now have practice drills for a variety of disasters (Nader & Mello, in press). It is essential to know what increases the risk of traumatization for students and/or for particular personality styles during and immediately after a disastrous event.

Risk factor awareness. Teachers can prevent or reduce posttrauma symptoms by reducing potential risk factors and minimizing youths' sense of culpability. The susceptibility of individuals to psychic trauma is a function of several factors, including past history of trauma and/or loss, prior psychosocial adjustment, personality makeup, developmental phase, content and intensity of the event, personal and emotional involvement in the event, proximity to injury and death, and available supports following the event (Chapter 19, "Identifying Psychological Trauma Victims," in this volume; Nader, 1998; Nader & Pynoos, 1993; Schwarz & Kowalski, 1991a, 1991b). It is

Table 2

Preparation

- Know about specific disasters.
- Prepare the environment.
- Know exits and safe locations.
- Know appropriate self-defense.
- Train and prepare students appropriately for specific events.
- Know what increases risk of traumatization.
- Know the strengths and weaknesses of co-workers and students.
- Know your own strengths and limitations.
- Know methods of contacting rescuers.
- Keep good records regarding students and the event before and immediately after the event.

Note
From Nader (1999).

essential for school staff to be prepared for and recognize the effects of specific risk factors for individual students.

Factors that increase the risk for increased symptoms following traumatic exposure (see Table 3) include traits and experiences occurring before, during, or after exposure that (a) decrease emotional distance from the traumatic episode and/or (b) create vulnerability. Some preexisting factors (e.g., depression, conduct disturbances) may become exaggerated. For example, students with conduct disturbances, or who identify with an aggressor, may become more aggressive. We have a great deal more to learn about how temperament (Chess & Thomas, 1991), personality style (Berens & Nardi, 1999), and other factors interact with aspects of a traumatic event to influence response over time (Nader, 2001). Although not studied in relation to traumatic stressors, youths with difficult temperaments are more vulnerable to nontraumatic stresses (Carey & McDevitt, 1995).

Staff members can protect students from increases in symptoms by avoiding actions that increase a youth's sense of responsibility or emotional proximity to an event.

Table 3

Factors That May Reduce Emotional Distance or Create Vulnerability

	Emotional Proximity Factors	Vulnerability Factors
Characteristics and Experiences That Occurred Before the Traumatic Event	Previous trauma or loss. Parent's previous trauma. Sensitivity. Undesirable or emotional interactions with those who later are killed.	Psychopathology. Family psychopathology. Characterological difficulties. Developmental difficulties. Parent's previous trauma. Attachment problems. Difficult temperament.
Experiences During the Traumatic Event	**With or without direct exposure:** Exposure to event horrors. Witnessing death, threat, or injury. Closeness to deceased, endangered, or injured. Worry about another person. Guilt (for actions or inactions before, during, or after event). Shame (for inabilities, actions, inactions). Sense of responsibility. Unsuccessful attempts to stop or prevent harm to someone.	**During exposure:** Exposure to event. Life-threat or threat of harm. Intense helplessness. Sense of threat to physical integrity. Sense of abandonment. Severe injury. Guilt or shame. Sense of personal damage. Witnessing death or mutilation.
Reactions or Experiences After the Traumatic Event	**With or without exposure:** Identification with victims. Identification with perpetrator(s). Perceived guilt or responsibility. Unsuccessful attempts to rescue or revive someone. View of victim's injuries or bodies. Specific contact with victims. Closeness to deceased, endangered, or injured.	**After direct exposure:** Loss of faith in self and/or others. Difficulty receiving comfort or discussing trauma/emotions. Overuse of avoidance. Overgeneralization of signs of threat. Poor family response. Overdependent caretakers. Lack of support. Parent(s) traumatized.

Note
Reprinted with permission from Nader (1999).

BEST COPY AVAILABLE

Anything that makes a youth feel more responsible for the outcome of the experience or for the well-being of persons subsequently injured or killed may reduce emotional distance and increase traumatization. Something as innocent as asking students to pray for a person or an outcome may increase a sense of culpability. Youths vary in the importance that they place on specific aspects of the event. A missed opportunity to assist may increase emotional proximity and responses. Unsuccessful actions taken (e.g., efforts to rescue or revive) may increase emotional responses.

Knowing the student body. Knowledge of individual personalities and coping styles can assist crisis response. Knowing students' personalities and styles under stress will provide important clues to how students may react during (and after) an event. In addition, schools with crisis drills may use this information to prepare students for their own reactions under stress and what they may most need to control for their own and others' safety. For example, a youth who draws attention to himself under stress may need to learn the dangers of doing so in a hostage situation.

Knowing the risk factors for committing violence may allay a crisis in the making (Nader & Mello, in press). To prevent ostracism (which may itself contribute to violence) of students who exhibit risk factors, the U.S. Departments of Education and Justice recommend procedures that ensure that school staff and students use early warning signs only for preliminary identification and referral purposes (Dwyer & Osher, 2000). Many schools have assembled a team of trained professionals who provide consultation, evaluation, and intervention for students who are struggling academically, behaviorally, and socially, including individual students who exhibit early warning signs (Dwyer & Osher, 2000).

Training to recognize and appropriately respond to (a) stress coping styles, (b) specific temperaments, and (c) troubled students may aid staff in responding to crisis situations. When feasible, mental health professionals can also assist information building, by circulating and retrieving scales that encourage teachers to think of students' styles and temperaments. Keeping the rating sheets in confidential psychological files will provide important information for those who intervene following a crisis.

Initial tracking of students. Appropriate disaster-preparation training includes training staff to keep accurate attendance lists and thorough event data. Accurate tracking and record keeping can prevent initial chaos and ongoing confusion. Searching for the whereabouts of injured children or bodies has been described by several school principals as an additional stressor in the aftermath of trauma. Failure to record the location of children (e.g., to multiple medical facilities and individuals) immediately following the event can exacerbate the stress responses of students and adults (Nader & Pynoos, 1993). Identifying which youth have had the most intense exposures and experiences and/or risk factors is necessary in all phases of intervention. Locations of injured or deceased students; a centralized list of exposed individuals (with exact location during the event); observed symptoms and/or identified risk factors; and thorough, accurate information about the event itself are essential. Efforts to locate, identify, and aid students and to reunite families without escalating a response are a part of initial crisis intervention.

Reuniting procedures. Separation of family members is a well-recognized source of postdisaster distress (McFarlane, 1989; Pynoos & Nader, 1989). Waiting children may become extremely anxious and may produce fantasies and concerns of threat and injury to significant others. These mental images may later become repetitive intrusive thoughts and may alter attachment behavior with family members and school personnel (Nader & Pynoos, 1993). The first sight of a parent may cause relief or may increase stress (e.g., in response to seeing the extremely distressed look on a parent's face) (Pynoos & Nader, 1989). Schools will need a preplanned policy and available backup team to provide a parental briefing, a transition period, and an appropriate location for reuniting children and parents (Nader & Pynoos, 1993).

Methods for problem behaviors. Trauma symptoms may include unruly classroom behaviors. In addition to learning methods of psychological first aid (Nader, 1999), teachers may also need methods to handle increased chaotic behaviors, anger, and aggression. Although not tested for use with traumatized youths, training in methods of interacting peacefully with angry students (Smith, 1999) and with "the spirited child" (Kurcinka, 1998) may prove useful.

During and Immediately After the Event

Although preparation can reduce injury and traumatization, no two catastrophic events are exactly alike. Thus, it is essential to assess the current situation. Nevertheless, a few guidelines may be helpful (Nader, 1999). When possible, place students in protected areas. If attackers are outside or in the building, remove students from attackers' sight and line of fire. Use knowledge of individual students to protect them and others from increased traumatization. If the attacker is in the room (e.g., a hostage situation), know the stages of a situation and act accordingly (Nader & Mello, in press). For example, keep students from engaging in behaviors that attract the attackers' attention during the initial phases of the situation. Avoid aggravating the hostage taker at all stages. During and after an event, protect students from the sights and sounds of horror. Reduce or prevent a sense of responsibility for outcomes. Reduce fear and helplessness without giving false information. Reinstate safety and a sense of safety by attending to safety issues (and, when appropriate, verbalizing actions taken; Nader, 1999).

Initial Interventions

Initial individual crisis intervention efforts may last up to six weeks and may overlap ongoing treatment efforts. Specific methods (e.g., recognition of responses to reminders, preparation for change) may be ongoing through the youth's recovery. Making certain that the youth is safe precedes any other interventions. Additionally, it is important to help the youth feel safe and nurtured (Nader, 1999). A brief meeting of a designated team member with relatives prior to their reunion with students can prevent looks of fear or horror and frightening outbursts that may exacerbate the youth's reactions (Nader, 1997b; Nader & Pynoos, 1993).

Early crisis intervention services permit identification of traumatic reminders and impede the development of undesirable defensive strategies. Although some form of "debriefing" is recommended within the first few days following a traumatic experience (Pynoos & Nader, 1988), an assessment must be made regarding the appropriate level or intensity of intervention. For large groups (e.g., classrooms) an initial group debriefing (e.g., classroom exercise) and assessment may precede individual debriefing. Youths may need to describe their experiences more than once to a good listener. However, in-depth examination of the experience should only occur when the youth is physically and emotionally ready and with a professional who is trained and skilled in treating childhood trauma. Experts in the field of childhood and adult trauma have observed that psychological harm has occurred when interviewers without the appropriate skill or training have elicited the details of a traumatic experience (Nader, 1997c; Swiss & Giller, 1993). In training sessions provided by the first author, school psychologists have told us that using methods simply by reading about them or having one basic training course has resulted in aggravating symptoms. Inadequate debriefings can hinder future treatment. In fact, psychoses and suicides have resulted from faulty post-trauma interviews (Swiss & Giller, 1993).

When the event has affected a large group or there are severe injuries for a small group, restoring safety, attending to physical needs, and restoring some normalcy will take priority over initial individual psychological interventions. With large groups and a limited number of trained clinicians, some children may have to wait for assessment and treatment while others are interviewed. Nevertheless, for most youths, assessment should begin no later than a month after the event has occurred, and initial clinical interventions no later than three months after (Nader & Pynoos, 1991). For some youths, symptoms may diminish or disappear after the first two days or two weeks after the event (Pynoos & Nader, 1989). Some symptoms may become disguised or less available to conscious memory after three months (Pynoos & Nader, 1993). Initial crisis methods are important to help affected youths and adults through the period of restoration and assessment preceding ongoing psychological interventions.

First Aid After Safety Is Restored

Following traumatic events, it is important to (a) recognize the impact of the event on the students' life and development and (b) seek skilled intervention and assistance (Table 4, on page 414). To have the energy to attend to increased school duties, teachers must engage in good self-care (e.g., physical, emotional, and spiritual). When a number of children in a classroom have been affected by the event, additional assistant(s) for the teacher are essential. Teachers' classroom duties will increase greatly. For example, record keeping, contacts (with support staff and parents), and student needs are likely to increase. Teachers may have to contend with students' increased behavioral problems (e.g., aggression, fear, hyperactivity, hypersensitivity) and academic difficulties (e.g., poor concentration, confusion, memory problems). Increased individual attention to affected children may be necessary. It is essential that teachers are freed to attend to these increased needs and that psychological interventions be left in the hands of trained mental health professionals. Nevertheless, even when the traumatic experience and treatment are off campus, a good flow of information among clinicians, teachers, and other appropriate adults will assist treatment. Specific traumas and traumatized individuals will necessitate work with classrooms or peer groups (see Treating the Traumatized Youth in Context later in this chapter).

Before (and after) initial interventions, students may repeatedly retell their experiences to anyone who will listen. This is true for hospitalized students as well. Inasmuch as a youth's initial retelling of the event may give clues to important aspects of experience and response (Joseph, Brewin, Yule, & Williams, 1991; Pynoos & Nader, 1989), it may be useful to write it down in detail (including the youth's subtle attributions of success or failure to individual episodes of the event). The youth may be willing to tell the story into a tape recorder.

Approaching the Traumatized Youth

Effective interventions include honoring the youth's individuality in new ways. It is essential throughout the assessment and intervention process to recognize and honor cultural differences that may affect posttrauma needs and reactions (Chapter 15, Cultural Considerations in Crisis Interventions, in this volume; Heras, 1992; Nader, Dubrow, & Stamm, 1999). Specific individual or group interventions (e.g., spiritual cleansing by holy persons) may be needed to reduce initial anxieties and make ongoing traumatic reactions distinguishable from fear reactions (Marsella, Friedman, Gerrity & Scurfield, 1996; Nader, 1997c). Avoid expecting youth or adults to be ready at the same time, for example, to grieve, express anger, or move out of regression. Recognize that each person exposed directly or indirectly to the event will have her or his own timing for response and recovery. Whether the event affects few or many, each individual has a different set of traumatic impressions combined with different concerns, personality, temperament, and prior experiences (Nader, 2001).

Immediately after an event, students will need clear instructions that enhance their safety and recovery. Although it is important to use age-appropriate language, it may be necessary to maintain the patience and gentleness reasonable for a much younger child when approaching the student (Nader, 1999). Adolescents especially may find it offensive to be treated as though they are younger. An increase in patience can be accomplished without using language or demeanor that insults or offends youths.

As a result of traumatic responses (e.g., regression, arousal), adults and youths may be functioning at more primitive cognitive and emotional levels (Nader, 1999, 2001). Arousal symptoms (e.g., sleep disturbances) and preoccupations (e.g., intrusive thoughts of the event) may interfere with memory and attention. As might be done with a young child, willingness to repeat instructions and to see that actions are carried out may be

Table 4

First Aid After Safety Is Restored

- Be a supportive presence.
- Ensure safety.
- Err toward caution in providing safety until judgment is restored.
- Listen without judging, interrupting, or probing.
- Avoid acting as inquisitor, reacting with excessive emotion, or making judgments about the child.
- With the child's permission, comfort; record important details of his/her story.
- When indicated or requested, provide age-appropriate factual information.
- Avoid false promises and inaccurate information.
- Observe and assess behavioral and personality changes.
- Recognize regressions.
- When indicated, be gently firm; set reasonable limits; reduce stress.
- Engage in good self-care.
- Be patient.
- Relax the normal schedule as needed until normalcy is restored.
- Recognize individuality and honor individual differences.
- Know your limitations and seek appropriate assistance.
- Refer if needed.
- Keep good records and share information with treatment clinicians (see Knowing the Student Body and Initial Tracking of Students in this chapter).

Note
Reprinted from Nader (1999).

required. Despite students' sense that nothing matters or that bad things happen even if you're good (so why bother), gentle firmness can help to reinstate students' recognition that rules still must be followed and there are consequences for behaviors.

Triage and Debriefing

With a reduction of chaos and an increased sense of safety, some acute anxiety symptoms will subside between two days and two weeks after an event (Pynoos & Nader, 1989). Other symptoms may have a delayed onset or be prominent at one phase and not another (Horowitz, 1973; Nader, 1994; 1997b). After a sense of physical and emotional safety has been restored, children will need factual information and a chance to tell their stories. All children should be assessed for their traumatic reactions.

Evaluation by a Trained Assessment Team

Evaluation of risk factors and face-to-face questioning of children are the best methods of evaluation (Nader, 1997c). Assessment requires providing an empathetic atmosphere within which individuals can talk, cry, express their feelings (or inability to feel), and relate their experiences. The assessment process may both assist recovery and identify individuals who are in need of more intensive individual intervention. Posttraumatic Stress Disorder (PTSD) symptoms have actually been reduced by skilled screening of children for their traumatic reactions (Nader, 1997c).

A number of measures are available for the assessment of child (Carlson, 1997; Nader, 1997c) and adult (Stamm, 1996) traumatic reactions. Some of the questionnaires examine symptoms in addition to PTSD that may result from individual or ongoing traumatic exposure. Training in the proper use of these instruments is important.

A few children may not report the full extent of their reactions because of initial emotional numbing or suppression of symptoms (Nader, 1994; Nader & Fairbanks, 1994). Some children suffer silently or express their distress symbolically. When assessing children's posttrauma reactions, it is important to be aware of nonverbal or abbreviated indicators of distress as well as overt risk factors for traumatic reactions. Specific symptoms such as startle response or other arousal symptoms may indicate greater distress than is reported. The need for further intervention may also be indicated by either the absence of emotion (in exposed children) or the intense, uncontrollable expression thereof (Weinberg, 1990). School staff can provide information regarding individual functioning that is crucial to triage. Because of their daily contact with students both before and after the crisis, teachers are able to note changes in school performance and behavior and provide valuable screening information. Similarly, school nurses are important to the triage process because they are aware of increased complaints and can identify individual children who somaticize their distress (Pynoos & Nader, 1988).

Tracking Classroom Indicators of Distress

All phases of trauma intervention should include cooperative efforts between mental health professionals and school personnel. The observations of teachers and school staff can provide needed information for mental health interventions. These observations will assist initial and ongoing assessments and provide information for clinical focus. Mental health and school professionals can work together to find solutions for some classroom behaviors.

Symptoms. Students may respond to traumatic experiences with the symptoms of PTSD and/or Acute Stress Disorder (see Chapter 31, The Cognitive-Behavioral Treatment of PTSD in Children and Adolescents, in this volume; Auerbach & Spirito, 1986; Pynoos & Nader, 1988; Terr, 1979, 1991; Williams, 1994), associated symptoms (e.g., grief, depression, anxiety; Nader, 1997a; Williams, 1994), and/or may develop patterns of behavior and interaction that affect the quality of life (Nader, 2001). Cognitive symptoms may include blurring of reality and fantasy boundaries, magical thinking, distortions of the incident itself, difficulty making decisions and problem solving, and concentration, memory, and attention deficits (Blom, Etkind, & Carr 1991; Pynoos & Nader, 1988, 1989; Terr, 1979; Williams 1994). Some symptoms may exacerbate response or prolong other symptoms. For example, disturbing traumatic dreams (Kramer, Schoen, & Kinney, 1984) or sleep disturbance can reinforce the persistence of other symptoms.

Changes and symbolic behaviors. Because youths express their distress, trauma-specific, and personal reactions in a number of ways, changes in behavior can be important indicators of distress. Examples include the young child who becomes more accident prone (e.g., for an excuse to cry) or the youth who finds more reasons to express anger. Moreover, amplification of behavioral tendencies may also indicate distress. For example, nurturing students may become more caregiving to their peers. Students who need to reduce classroom stress levels may engage in more distracting behaviors.

Youths may take on different roles over time in response to intense traumatic impressions or role identifications (Nader, 2001). For example, a youth who witnessed a shooting or was repeatedly abused may become aggressive in response to helplessness, rage, or identification with the aggressor. Alternatively, the same youth may become a frequent rescuer in response to a traumatic need or desire to rescue an injured or killed friend. Survivor guilt, curiosity, or other traumatic reactions may result in putting self in peril while attempting to rescue others.

A youth's posttrauma preoccupations may permeate his or her life overtly (e.g., through retelling or reenacting the experience) and/or symbolically (e.g., through choices of activities, movies, or behaviors). Reenactments of traumatic episodes may be subtle or obvious. Games involving twirling after a tornado, crawling into small spaces after rescue from a well, frequent roller coaster rides after a hurricane or rollover vehicle accident, or radio rescue games and activities after an airplane crash may be fairly easy to link to the event. The link to the experience of more subtle behaviors, however, such as particular body tensions or changes in the frequency or quality of usual play or activities (e.g., those symbolic of rescuing, dying, or conquering assailants) may go unrecognized. The presence of nontraumatized observers on the playground may both relieve overtaxed and traumatized teachers and provide intensified observation.

In addition to actual aspects of the event, intense emotions and patterns of thought may be symbolically reenacted. A nine-year-old boy who normally discussed his emotions and needs with family and friends symbolically reenacted his trauma experience by passively waiting and hoping people would approach him to provide support and comfort for his emotional pain. During a shooting at his church, he hid behind a church pew hoping and waiting for rescue while a gunman shot others. Watching "Top Gun" over and over was a teenage girl's way of reminding herself that you can overcome the devastation of tragic death. Her parents and brother were strangled to death before police rescued her. Increased reading about bloody murders or watching bloody horror movies may be an attempt to desensitize oneself against repeating horrible images of bloody deaths. These symbolic preoccupations may be important clues to a needed focus of later treatment. School staff assistance in providing needed information about changes and symbolic behaviors will help initial and ongoing efforts.

Regressions. Especially in the midst of posttrauma stress and chaos, regression may be difficult to recognize (Nader, 1999). Loss of skills may be complicated or exaggerated by other trauma symptoms (e.g., lack of sleep, cognitive difficulties, and/or preoccupations). Regression and other trauma symptoms may look like laziness, sloppiness, defiance, or attention-getting behaviors. Youths may function at more primitive levels in general. For example, they may use more concrete and literal levels of processing information, be more easily distracted, be less imaginative, or engage in activities characteristic of someone younger. It is important to learn to identify individual regressive tendencies and personality changes. Good preliminary record keeping will assist this recognition. Moreover, it is important to recognize a youth's functioning emotional age (which may change from contact to contact). While youth should be spoken to in age-appropriate language, adaptations to emotional functioning level may need to be made. Even instructions stated simply may need to be repeated. Patience, understanding, and the gentle firmness used with a younger child may be necessary. For example, for a traumatized eight-year-old, it may be necessary to use a tone or the patience you would use with a two-year-old while speaking in the language of the eight-year-old child (Nader, 1999).

Clinical Interviews

Initial interventions may include one or two sessions of each of the following: psychoeducational groups, behavior management techniques for teachers, and individual psychotherapy or debriefing sessions. These treatments serve as preludes or adjuncts to any needed ongoing treatments. For example, small group meetings with homogeneous groups such as classroom peers can be used to debrief, triage, or provide ongoing support for students (Blom et al., 1991; Nader & Mello, 2000; Pynoos & Nader, 1988; Williams, 1994).

One initial clinical interview (e.g., Pynoos & Eth, 1986) has provided additional assessment, prevented escalation of symptoms, and/or prepared for any needed future therapy (Nader, 2001). Although rarely sufficient treatment for moderate to severe trauma, two clinical interviews have reduced trauma levels and prevented the escalation of depression (Goenjian et al., 1997). Delivered without the appropriate wisdom, understanding, and skill, an initial debriefing or treatment session can deter future needed treatment or worsen traumatic response (Nader, 1997c). These interviews should be conducted by a mental health professional with a sufficient background in childhood psychotherapy and trauma as well as extended training and supervision in the use of a specific childhood trauma method (Nader, 2001; Webb, 1999).

Successful initial interviews progress in rhythm with the youth (Nader, 1994; 1997a). The goals of beginning sessions include: (a) creating safety in the therapy setting; (b) establishing the willingness of the interviewer to hear everything; (c) enhancing trust-building; (d) permitting repetition; (e) restoring a sense of normal fears and personal capability; (f) accomplishing or setting the stage for regaining a sense of mastery; (g) exploring the youth's subjective experience and helping the youth to understand the meaning of his or her responses; (h) providing cognitive reappraisals for prior states of helplessness and/or reducing the overpowering experience of continued intrusive imagery and traumatic reminders; (i) providing a sense of relief from having to carry the deepest wound alone; (j) inviting (beginning or final) resolution of guilt, grief, identifications, rage, revenge, or aggressive fantasies in order to prevent the debilitating preoccupation with or the behavioral expression of them; and (k) recognizing current stresses and their interplay with traumatic responses (Nader & Mello, 2000; Pynoos & Nader, 1988; Williams, 1994).

When there was intense concern about someone during an event, one conjoint and/or family session may reduce the effects of these concerns (Nader, 1997b; Pynoos & Nader, 1988). For example, a youth may develop anxious attachment or anger toward a sibling endangered during an event. A meeting with parents of traumatized students permits the clinician to help them understand changes in their children, to prepare them for the course of the traumatic stress response, and to answer their questions (Nader, 1999). Similarly, meeting individually and in groups with teachers can prepare the teachers for the traumatic stress response, train them in appropriate behavioral management, and provide student-specific guidance.

Referral for Additional Treatment

Students with moderate to severe trauma or specific associated reactions will need ongoing treatment. There are a number of ways of returning a youth to a normal developmental pathway after traumatic exposure (see Section V of this volume). Restoring a sense of safety, competence, confidence, and wholeness as well as reducing symptoms of PTSD, anxiety, and depression generally occur in the course of many treatments.

421

Treating the Traumatized Youth in Context

When the event has had school- or community-wide impact, adults and youths will require specific and general assistance. Even if a youth experiences a traumatic event alone (e.g., a long fall or a drowning), rescuers and those who care about the youth may be traumatized by their own reactions to the youth's endangerment, injury, or death. Traumatized parents and teachers often have more difficulty engaging in their normal roles with youth (e.g., teaching, grading, disciplining, and protecting). Parents are often less emotionally available (Bloch, Silber, & Perry, 1956) and may make less physical contact with their children (Field, Seligman, Scafidi, & Schanberg, 1996) following traumatic events. Traumatized or not, teachers, students, support staff, and administrators will need assistance from clinicians to understand the needs of affected individuals. All individuals in physical or emotional proximity to traumatic events will need an initial assessment of their risk factors and reactions, an initial intervention session, planning for appropriate additional sessions and/or support, and recognition of their special needs.

Location

After school or community events, individual interventions are most effectively pursued within the school environment (Auerbach & Spirito, 1986; Nader, 1997b; Pynoos & Nader, 1988; Shaw, 1997; Williams, 1994). School is a familiar, safe setting for youths. Because the students are already in the building and transportation is not a problem, it provides a greater level of appointment compliance. When the trauma has occurred at the school, on-site treatment allows the individual, when ready, to work through traumatic material in the location where it occurred. When the event has occurred off campus, school interventions may also be needed.

Off-Campus Traumatic Events

When a youth is traumatized or killed off campus, all students in the school may be affected by the premature confrontation with their own vulnerabilities. After a death, students will need a chance to discuss the event (or ailment) and memorialize the dead. Decisions will be made with or for the classroom regarding memorial acts or interactions with the surviving relatives of the deceased (e.g., making a scrapbook of their schoolwork, activities, and friends). Specific youth (e.g., close friends, youths identified or in conflict with the deceased) will need assistance in addition to special discussion, assemblies, or classroom consultations.

Students who are traumatized off campus or who have remained off campus with injuries may need assistance with reintegration into the classroom. They may have specialized needs (e.g., adjusted academic instruction and activities). In addition to individual treatment, meetings with the student's class before the youth reenters and during reintegration may be important. Meeting with the class before the youth's (or teacher's) return permits classmates to (a) express and resolve fears; (b) understand any injuries, behaviors, and other changes in the youth; and (c) develop a supportive attitude toward the physically and/or emotionally injured individual. For example, a boy who was shot in a drive-by gang shooting was afraid to return to school because of his eye patch. To reintegrate him back into the classroom, the treating clinician discussed with the class what had happened to the boy, how he was doing, how the shooting might still bother him (e.g., reminders, seeing with the eye patch, feeling safe), and how classmates could help him to feel comfortable returning to school. His classmates needed assistance to understand that, under the eye patch, the shooting victim was still the same person. The patch was not something to be feared and his injury was not contagious.

Classroom and small group interventions can assist peers with understanding seemingly strange behaviors (e.g., head banging by an elementary school child with previous head trauma). The classmates of one boy, who was badly injured in a school disaster, were assisted to recognize his difficulty tolerating hovering students, loud noises, and separation from protecting parents. They accepted his mother's presence and gradual removal from his side, and learned to allow him space and recovery time when he became overwhelmed and irritable. A peer support group provided youth liaisons in the classroom to assist him through difficult periods. Over time, the classmates were assisted to understand any emotional and symptomatic regression that occurred as emotional numbing wore off and issues of grief and rage were faced.

On-Campus Traumatic Events

Everything that follows an on-campus traumatic event affects students and teachers. Beginning during the chaos of the rescue effort and continuing through the recovery of the last youth, the actions of teachers, students, and staff are perceived through traumatized eyes and interact with traumatic thoughts and emotions to worsen or alleviate symptoms. A traumatized youth cannot be treated by group or individual treatments alone.

On-campus traumatic events sometimes amplify the sources of potential problems as well as adding new difficulties. At a time when rallying together and around one another is needed, trauma may promote divisiveness between staff or student groups (Nader, 1997b). For example, already existing differences may become highlighted (e.g., core vs. elective or support staff). Additionally, out of fear, anxiety, and/or a sense of self-preservation, adults and youths look for ways of distinguishing themselves from the traumatized and from the traumatic experience. Elementary school students may decide that only youths with a particular quality (e.g., a broken arm, in a particular grade, with a particular habit or look) are vulnerable to severe injury or death. Adolescents and adults may covertly think similar thoughts and/or may decide that victimization was a consequence of previously unknown qualities (e.g., unknown drug use, covert acts, links to undesirable individuals, inability to take charge and protect themselves). This magical thinking (e.g., "I'm safe because I don't have those qualities") or a tendency to attribute characteristics of vulnerability to the victim(s) and absent from the self may expand to objects associated with the event. For example, students may want to destroy objects or locations associated with the event (e.g., a building or room where the trauma occurred, the school ground item on which someone was injured or killed). The result of this kind of thinking can be unkindness, ostracism, ignoring, depriving of needed services, focusing on differences, overt or covert requests for silence (e.g., about the event, emotional responses), and/or an expressed desire that the event and its impact be put (prematurely) behind them. These are, in fact, acts of cruelty, neglect, and poor modeling for youths and are dangerous. Youths with unresolved traumas are well represented among those who commit violence or become otherwise mentally disturbed (American Academy of Child and Adolescent Psychiatry, 1999; American Psychological Association, 1999; Nader, 2001; National School Safety Center, 1999).

When a traumatic event occurs on the school grounds, the entire school community will need access to treatment resources. Those who are not traumatized are needed to assist the traumatized and those individuals who have increased crisis-related responsibilities. All individuals affected by an event will need some level of intervention. Listed below are some of the expected responsibilities and needs of relevant groups following the traumatic event. Some of them require preparation before a disaster occurs (see also Preparation for Initial Crisis Intervention at the beginning of this chapter).

Administrators. After the initial emergency response, administrators will need an initial session or debriefing in order to process the traumatic event and their behaviors during the event and in the immediate aftermath. Not only does this provide some psychological relief, but it also provides first-hand experience in the benefit of psychological intervention. In the weeks that follow, these individuals will face the daunting task of spearheading the restoration of the school community. They may fight to maintain a sense of control and thus hinder their own recovery. Special care must be given to providing appropriate psychological assistance during periods when the administrators do not have to be in charge (e.g., Saturdays, multiple weekly sessions during summer break).

District-level administrators will need good public relations assistance and good support systems, including family and friends, disaster response and funding agencies (e.g., American Red Cross, fire department, Federal Emergency Management Agency, local businesses), local government, and community leaders. Personal debriefing or treatment, if indicated, must recognize the need to maintain authority during the work week. After a traumatic event, school superintendents will be required not only to remain knowledgeable, but also to become involved in the traumatized school in new ways. Executive interventions must reinforce local school authority. Increased visibility and support and providing a buffer between the external world and the school is essential (e.g., becoming the contact location for the media). Tact and reverence must be ensured in the memorialization of the dead or the honoring of heroes. It may be necessary to contend with the jealousies of other schools, the community not wanting to hear about the event anymore, and the need to rally support around the school and its children.

Regular executive planning meetings that include the principal, consultants, and treatment team leader can provide support, information updates, and planning for needs and situations that arise. An additional planning group that includes leaders from the business community and supporting agencies, school community leaders, treatment team leader or an outside consultant, and other appropriate representatives can prevent specific problems. For example, this group can rally support and prevent the larger community from impeding ongoing recovery. The community can be kept informed of continued difficulties faced by the traumatized youth. In one situation, this type of team intervened by providing factual information about the ongoing recovery process when parents from surrounding schools complained of the continued attention to the stricken school. Moreover, they developed solutions for specific problems (e.g., fundraising, relief for overwhelmed parents and teachers). When, for example, parents from an adjacent school provided babysitting services for parents of traumatized children, the parents could better engage in healing interactions with their clinging and upset children (Nader, 1997b).

Administrators will also need to appoint a consulting mental health professional or a qualified school psychologist to assess the students' continuing functioning until their graduation. This appointee must be able to maintain an objective stance, free from the effects of school politics, and have ample time to re-assess students individually and in the classroom. He or she will (a) reassess students at regular intervals (at least once per year for the first three years and then once every other year), (b) provide feedback and advocacy regarding the students' (and their teachers') ongoing needs, and (c) help to find appropriate interventions for problems that arise over time. Feedback from high school teachers suggests that students traumatized in elementary or middle school may continue to have problems throughout their school years. Some problems arise as the traumatic experience interacts with age and life experience. These and other difficulties may occur even though PTSD symptoms have been reduced.

School principals will need support from their supervisors, additional staff, and a specific trusted mental health professional as confidant. These supports and any needed individual treatment will help foster strong leadership. Without strong leadership, posttrauma agitation among parent and staff groups may divert needed focus from the children. Administrators need to anticipate lines of division that may occur between staff (e.g., full-time vs. part-time teachers, traumatized vs. nontraumatized staff, preexisting cliques or feuds). Divisiveness, distrust, anger, scapegoating, and ostracizing the more traumatized school community members may escalate. Symptoms may escalate throughout the school when, for example, there is increased noise from construction, increased anxiety because of anniversaries, holidays, and other traumatic reminders. Severely affected classrooms may need full-time teaching assistants, and there may be a general increased need for school staff and relief staff. During the healing process, a strong, directive administrative style is helpful in making school personnel feel supported, protected, guided, and able to provide support to each other (Nader & Pynoos, 1993). Assistants may be needed to attend to duties outside of the range and availability of the existing administrator, for example, contending with the volume and intensity of angry behaviors, anxieties, intrusions, and demands of parents, the press, and others after a school disaster (Nader & Pynöos, 1993).

Teachers. To function well personally and professionally, teachers will need assistance with their own reactions to the event and with the increase in their duties and demands. For their personal traumatic reactions, off-site treatment sessions with guarantees of privacy are best. Even if school administrators oversee funds, the names and status of those in treatment is a confidential matter. The consultant can check clinician lists to ensure accuracy. Additionally, teachers will need assistance with their personal and professional reactions to traumatized students, with recognizing and understanding new behaviors (e.g., regressions, outbursts, quiet suffering), with the easiest methods of noting and tracking behaviors, and with ways to rebuild and relax in the midst of chaos. In a multidisciplinary, school-based intervention program, therapists can serve as consultants to furnish ongoing input and education to teachers and staff and help them understand the youths' behavioral extremes (Waterbury, 1996). Many "problem behaviors" are trauma-generated survival mechanisms, expressions of fear and anger, responses to neurochemical changes, responses to symptoms, and/or regressions. Teachers can become pivotal in recognizing skills or deficiencies and reducing trauma-induced disruptions in a way that enhances recovery. Combining information from the teacher with classroom observations, the experienced clinician can then interpret behaviors and recommend solutions that have worked in similar circumstances.

Crisis intervention team. The treatment and screening teams may include some common members. All personnel who may come in contact with youths following trauma should be trained in harmless methods of approaching traumatized youths. It is essential that those who intervene not exceed their abilities to assist. Treating traumatized children requires knowledge and experience in child development, psychotherapeutic principles, youth and adult posttraumatic reactions and treatment needs (Wilson & Raphael, 1993), the interaction of trauma and grief (Nader, 1996, 1997a), the long-term consequences of specific experiences (Nader, 2001), and treatment techniques adapted for traumatized children. All treatment methods for childhood trauma require preexisting knowledge and a prescribed period of training and supervision.

All clinicians involved must maintain a therapeutic stance, for example, by avoiding adopting the parent's rage over injuries to their children and by remaining a part of a team effort to prevent interventionists working against each other or exacerbating reactions (Nader, 1997b; Nader & Pynoos, 1993). Using an outside consultant with significant crisis intervention experience following mass disasters can provide additional expertise and an objective approach during all phases of posttrauma response: planning, first aid, early and brief interventions, and long-term interventions. An experienced consultant uses knowledge from multiple and varied events and should have a greater store of problem-solving tools and ideas to anticipate and prevent or minimize particular aspects of traumatic response.

Other outside assistance. Youths who generalize their fears have, in some ways, had a more difficult time than other traumatized youths (Nader & Pynoos, 1993). To clarify youths' questions and confusions and to promote cognitive discrimination, additional outside assistance may be brought in to give factual explanations of the event.

For example, paramedics might describe issues related to resuscitation. The weatherman might explain how a tornado or hurricane happens and is spotted. Care must be taken by these individuals not to make youths even more hypervigilant than they already are. For example, if the weatherman tells them how to spot warning signals in animals for earthquakes or severe weather, they may become anxious about animal behaviors in addition to their other fears (e.g., of rattling windows, high winds).

Conclusions

Effective individual crisis intervention begins with care in attitude and approach toward traumatized students. Although each traumatic situation is unique and responses during an event are not always predictable, preparatory efforts can help school staff reduce the adverse effects of trauma. Preparatory efforts such as good record keeping (e.g., personal profile of each youth), readiness for the effects of trauma (e.g., ready funding, rescue, and repair sources), identified posttrauma staff assignments (e.g., a person and a backup to notify police, a team to notify and debrief parents), and preparatory training (e.g., response to specific traumas, to cultural needs following trauma or death, methods of handling posttrauma behavior) can reduce the damage caused by catastrophic events and assist recovery efforts.

References

American Academy of Child and Adolescent Psychiatry. (1999). *Understanding violent behavior in children and adolescents.* Available online: www.aacap.org/publications/factsfam/behavior.htm

American Psychological Association. (1999). *Warning signs of teen violence*. Available online: www.apa.org

Auerbach, S. M., & Spirito, A. (1986). Crisis intervention with children exposed to natural disasters. In S. M. Auerbach & A. L. Stolberg (Eds.), *Crisis intervention with children and families* (pp. 191-202). Washington, DC: Hemisphere.

Berens, L. V., & Nardi, D. (1999). *The 16 sixteen personality types: Descriptions for self-discovery.* Huntington Beach, CA: Telos Publications.

Bloch, D., Silber, E., & Perry, S. (1956). Some factors in the emotional reaction of children to disaster. *American Journal of Psychiatry, 113*, 416-422.

Blom, G. E., Etkind, S. L., & Carr, W. J. (1991). Psychological interventions after child and adolescent disasters in the community. *Child Psychiatry and Human Development, 21*, 257-266.

Carey, W. B., & McDevitt, S. C. (1995). *Coping with children's temperament*. New York: Basic Books.

Carlson, E. B. (1997). *Trauma assessments*. New York: Guilford Press.

Chess, S., & Thomas A. (1991). Temperament. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp.145-159). Baltimore: Williams & Wilkins.

Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide*. Washington, DC: Departments of Education and Justice.

Field, T., Seligman, S., Scafidi, F., & Schanberg, S. (1996). Alleviating posttraumatic stress in children following Hurricane Andrew. *Journal of Applied Developmental Psychology, 17*, 37-50.

Goenjian, A. K., Karayan, I., Pynoos, R. S., Minassian, D., Najarian, L. M., Steinberg, A. M., & Fairbanks, L. A. (1997). Outcome of psychotherapy among early adolescents after trauma. *American Journal of Psychiatry, 154*, 536-542.

Heras, P. (1992). Cultural considerations in the assessment and treatment of child sexual abuse. *Journal of Child Sexual Abuse, 1*, 119-132.

Horowitz, M. (1973). Phase-oriented treatment of stress response syndromes. *American Journal of Psychotherapy, 27*, 506-515.

Joseph, S. A., Brewin, C. R., Yule, W., & Williams, R. (1991). Causal attributions and psychiatric symptoms in survivors of the Herald of Free Enterprise disaster. *British Journal of Psychiatry*, 159, 542-546.

Kramer, M., Schoen, L. S., & Kinney, L. (1984). The dream experience in dream-disturbed Vietnam veterans. In B. A. Van der Kolk (Ed.), *Post-traumatic stress disorder: Psychological and biological sequelae* (pp. 81-95). Washington, DC: American Psychiatric Press.

Kurcinka, M. S. (1998). *Raising your spirited child* (2nd ed.). New York: Harper Perennial.

Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (Eds.). (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research and clinical applications*. Washington, DC: American Psychological Association.

McFarlane, A. C. (1989). The prevention and management of the psychiatric morbidity of natural disasters: An Australian experience. *Stress Medicine*, 5, 29-36.

Nader, K. (1994). Countertransference in treating trauma and victimization in childhood. In J. Wilson & J. Lindy (Eds.), *Countertransference in the treatment of posttraumatic stress disorder* (pp. 179-205). New York: Guilford Press.

Nader, K. (1996). Assessing traumatic experiences in children. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma & PTSD* (pp. 291-348). New York: Guilford Press.

Nader, K. (1996b). Children's exposure to violence & disaster. In C. A. Corr & D. M. Corr (Eds.), *Handbook of childhood death and bereavement* (pp.201-222). New York: Springer Publishing.

Nader, K. (1997a). Childhood traumatic loss: The interaction of trauma and grief. In C. R. Figley, B. E. Bride & N. Mazza (Eds.), *Death and trauma: The traumatology of grieving* (pp. 17-41). Washington, DC: Taylor and Francis.

Nader, K. (1997b). Treating traumatic grief in systems. In C. R. Figley, B. E. Bride, & N. Mazza (Eds.), *Death and trauma: The traumatology of grieving* (pp. 159-192). Washington, DC: Taylor and Francis.

Nader, K. (1998). Violence: Effects of a parents' previous trauma on currently traumatized children. In Y. Daniel (Ed.), *An international handbook of multigenerational legacies of trauma* (pp. 571-583). New York: Plenum Press.

Nader, K. (1999). *Psychological first aid for trauma, grief and traumatic grief* (3rd ed.). Austin, TX: Two Suns.

Nader, K. (2001). Treatment methods for childhood trauma. In J. P. Wilson, M. Friedman, & J. Lindy (Eds.), *Treating psychological trauma and PTSD*. New York: Guilford Press.

Nader, K., Dubrow, N., & Stamm, B. (Eds.). (1999). *Honoring differences: Cultural issues in the treatment of traumatic stress*. Philadelphia: Taylor and Francis.

Nader, K., & Fairbanks, L. (1994). The suppression of reexperiencing: Impulse control and somatic symptoms in children following traumatic exposure. *Anxiety, Stress and Coping: An International Journal*, 7, 229-239.

Nader, K., & Mello, C. (2000). Interactive trauma/grief focused therapy. In P. Lehmann & N. F. Coady (Eds.), *Theoretical perspectives for direct social work practice: A generalist-eclectic approach* (pp. 383-401). New York: Springer Publishing.

Nader, K., & Mello, C. (in press). Shootings and hostage takings. In A. M. LaGreca, W. K. Silverman, E. M. Vernberg, & M. E. Roberts (Eds.), *Helping children cope with disasters: Integrating research and practice*. Washington, DC: American Psychological Association.

Nader, K., & Pynoos, R. (1991). Play and drawing as tools for interviewing traumatized children. In C. Schaeffer, K. Gitlin, & A. Sandgrund (Eds.), *Play diagnosis, and assessment* (pp. 375-389). New York: Wiley.

Nader, K., & Pynoos, R. (1993). School disaster: Planning initial interventions. *Journal of Social Behavior and Personality*, 8, 299-320.

National School Safety Center. (1999). *School associated violent deaths.* Available online: www.nsscl.org

Pynoos, R. S., & Eth, S. (1986). Witness to violence: The child interview. *The Journal of the American Academy of Child Psychiatry, 25*, 306-319.

Pynoos, R., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*, 445-473.

Pynoos, R. S., & Nader, K. (1989). Children's memory and proximity to violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 236-241.

Pynoos, R. S., & Nader, K. (1993). Issues in the treatment of post traumatic stress disorder in children and adolescents. In J. Wilson & B. Raphael (Eds.), *The international handbook of traumatic stress syndromes* (pp. 535-539). New York: Plenum Press.

Schwarz, E. D., & Kowalski, J. M. (1991a). Malignant memories: PTSD in children and adults after a school shooting. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 936-944.

Schwarz, E. D., & Kowalski, J. M. (1991b). Posttraumatic stress disorder after a school shooting: Effects of symptom threshold selection and diagnosis by DSM-III-R, or proposed DSM-IV. *American Journal of Psychiatry, 148*, 592-597.

Shaw, J. A. (1997). Posttraumatic stress disorder: Acute and long-term responses to trauma and disaster. In C. S. Fullerton & R. J. Ursano (Eds.), *Children of the storm: A study of school children and hurricane Andrew* (pp. 123-143). Washington, DC: American Psychiatric Press.

Smith, M. L. (1999). *The peaceful intervention program*. Lawrence, KS: Malcolm Smith Consulting.

Stamm, B. H. (Ed.). (1996). *Measurement of stress, trauma and adaptation*. Lutherville, MD: Sidran Press.

Swiss, S., & Giller, J. E. (1993). Rape as a crime of war: A medical perspective. *Journal of the American Medical Association, 270*, 612-615.

Terr, L. C. (1979). Children of Chowchilla: A study of psychic trauma. *Psychoanalytic Study of the Child, 34*, 547-623.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*, 10-20.

Waterbury, M. (1996). School interventions for dissociative children. In J. L. Silberg (Ed.), *The dissociative child: Diagnosis, treatment and management* (pp. 315-329). Lutherville, MD: Sidran Press.

Webb, N. B. (1999). (Ed.) *Play therapy with children in crisis: Individual, group and family treatments* (2nd ed.). New York: Guilford Press.

Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions following trauma at school. *Professional Psychology: Research and Practice, 21*, 271-278.

Williams, M. B. (1994). Intervention with child victims of trauma in the school setting. In M. B. Williams & J. F. Sommer (Eds.), *Handbook of post-traumatic therapy* (pp. 69-77). Westport, CT: Greenwood Press.

Wilson, J. P., & Raphael, B. (Eds.). (1993). *The international handbook of traumatic stress syndromes*. New York: Plenum Press.

Section

4

Secondary Prevention: Responding to Specific Crises

Just as a crisis response must be tailored to the specific developmental and cultural characteristics of the crisis victims, it must also take into account the unique challenges offered by different types of crisis events. Thus, this section includes chapters that focus on specific crises. The chapters in this section follow a similar format. Specifically, each chapter begins by identifying the unique issues or problems generated by the crisis event, then it reviews special developmental and cultural issues. Finally, each chapter concludes with a discussion of the unique or special actions schools should take to prevent and/or respond to the specific crisis. The crisis events discussed in this section are natural disasters (Chapter 22 by Philip Lazarus, Shane Jimerson, and Stephen Brock), sudden and unexpected death (Chapter 23 by Shane Jimerson and Lee Huff), school violence (Chapter 24 by Michael Brown), child maltreatment (Chapter 25 by Linda Webster and Jody Browning), suicidal ideation and behavior (Chapter 26 by Richard Lieberman and John Davis), completed suicide (Chapter 27 by Stephen Brock), war (Chapter 28 by Avigdor Klingman), and refugee status (Chapter 29 by Patricia del Valle).

22

Natural Disasters

危機

Philip J. Lazarus, Ph.D.
Florida International University

Shane R. Jimerson, Ph.D.
University of California, Santa Barbara

Stephen E. Brock, Ph.D.
California State University, Sacramento

In the early morning hours of August 24, 1992, Hurricane Andrew slammed into south Florida leaving in its wake broken homes, broken lives, and broken dreams. Approximately 250,000 individuals were left homeless; 75,000 homes were destroyed; 1.5 million people were left without water, electricity, and telephones; 108 schools were damaged and 3 were destroyed. As superintendent Octavio Visiedo of Miami-Dade County Public Schools said: "While we were ready for Hurricane Andrew, nothing absolutely nothing prepared us for what we saw after the storm" (Lazarus, 1993).

Within the past decade, a great deal has been learned about how children respond to natural disasters (e.g., Bolton, O'Ryan, Udwin, Boyle, & Yule, 2000) and what school personnel can do to facilitate the rebuilding and healing process (e.g., Prinstein, La Greca, Vernberg, & Silverman, 1996). The purpose of this chapter is to explain the impact of natural disasters on children and how healing can begin in the aftermath of such crises.

Unique Crisis Issues

Natural disasters present a variety of unique issues and coping challenges. Among them are issues associated with specific types of natural disasters, the need to relocate when home and/or community have been destroyed, the role of the family in lessening or exacerbating the trauma, emotional reactions, and coping techniques.

Issues Associated with Specific Disasters

Hurricanes. These events are usually predicted days to weeks in advance, giving communities time to prepare. Unfortunately, such predictions are inexact. Although communities can be made aware of potential danger, there is always uncertainty about the exact location of a storm's strike. While these predictions give families time to gather supplies and prepare their homes and children, these activities in and of themselves may generate fear and anxiety (Zenere & Lazarus, 1999).

When a hurricane strikes, victims experience intense thunder, rain, lightning, and wind. For example, the roaring of the winds during Hurricane Andrew were likened to freight trains. Consequently, startle reactions to sounds are especially acute in the months that follow, and subsequent storms may trigger panic reactions. Following Hurricane Andrew, for example, when it rained some children cried and needed reassurance that a hurricane was not coming.

Immediate reactions to hurricanes can include emotional and physical exhaustion. For example, after Hurricane Andrew, survivors were required to stay awake for days to deal with the disaster's aftermath. Emotionally, guilt is common. In some instances guilt may be due to failure to have taken necessary precautions (e.g., to buy hurricane shutters). In other instances victims may experience survivor guilt (e.g., that they were not harmed, while others were killed or injured) (Young, 1997). In studies of children's reactions to Hurricane Hugo in Charleston, South Carolina, greater symptomatology was associated with more frightening experiences during the storm and with greater levels of damage to their homes (Lonigan, Shannon, Finch, & Daugherty, 1991; Lonigan, Shannon, Taylor, Finch, & Sallee, 1994; Shannon, Lonigan, Finch, & Taylor, 1994).

Although the hurricane event may only last a short period, survivors can be involved with the disaster aftermath for months or even years. Property destruction can be overwhelming. For example, following Hurricane Andrew 90% of some neighborhoods were destroyed. After the hurricane, the smells of rotten food, decay, and debris were common and created coping challenges. In south Florida, the electricity was no longer working. As a result, there was no air conditioning and mildew was common on the walls in houses that were still standing.

In attempts to reconstruct their lives following such a disaster, families will be required to deal with multiple people and agencies [e.g., insurance adjusters, contractors, electricians, roofers, the Red Cross, the Federal Emergency Management Agency (FEMA), and the Salvation Army]. The first author found that the details people had to attend to following Hurricane Andrew were overwhelming, and many became emotionally and physically exhausted within about six months to a year. The impact and duration were greatest for those who had to evacuate their homes or who had no homes when they returned. The fact that reconstruction takes so long may lead to periods of depression and disillusionment (Lazarus & Jackson, 1993).

Earthquakes. Aftershocks differentiate earthquakes from other natural disasters. Since there is no clearly defined endpoint, the disruptions caused by continued tremors may increase psychological distress (Zenere, 2001). For example, months after a series of earthquakes that jolted Turkey, families continued to sleep outdoors and were afraid to return to their homes because of the legitimate fear that homes could collapse if another earthquake occurred. In addition, some individuals were unable to fall asleep until after the time that the first major earthquake struck, which kept them up until the middle of the night.

Unlike other natural disasters (e.g., hurricanes and certain types of floods), earthquakes occur with virtually no warning. This fact limits the ability of disaster victims to make the psychological adjustments that can facilitate coping. This relative lack of predictability also significantly lessens feelings of controllability. While one can climb to higher ground during a flood, or install storm shutters before a hurricane, there is usually no advance warning or immediate preparation with earthquakes.

Fears of being buried alive, pinned down, suffocating, and of not being rescued are common (Young, 1997). In addition, survivors may have to cope with visions of destruction; sounds of explosions, and the rumbling of aftershocks; smells of toxic fumes and smoke; and tastes of soot, rubber, and smoke. Given these observations, it is not surprising that there may be increases in psychiatric morbidity following an earthquake. For instance, it was found that after the Yunnan earthquake, which struck Asia in November 1988, morbidity rates doubled [National Center for Post Traumatic Stress Disorder (PTSD), 2000]. After the 1999 earthquake in Taiwan, up to 95% of the children in the high exposure area experienced PTSD (National Center for PTSD, 2000).

Tornadoes. Like earthquakes, tornadoes can bring mass destruction in a matter of minutes, and individuals typically have little time to prepare Confusion and frustration often follow. For example, imagine awakening at 1:00 AM and trying to determine what to do when the entire house is being rocked.

Similar to a hurricane, people experience sensations during tornadoes that may generate coping challenges. For example, the sound of roaring winds may later make it difficult to tolerate the sound of trains or jets. In addition, as with hurricanes, it can be difficult to cope with the sights and smells of destruction.

Given the capricious nature of tornadoes, survivor guilt has been observed to be an especially common coping challenge. For example, the first author observed this reaction among children in the aftermath of tornadoes that devastated central Florida. Some children expressed guilt that they still had a house to live in while their friend next door did not. In addition, a study following a tornado in Mississippi, which caused considerable damage and loss of life, revealed significant associations between children's disturbances and having been in the impact zone, been injured, and having experienced the death of relatives (Bloch, Silber, & Perry, 1956).

Floods. These events are one of the most common natural disasters. Flash floods are the most dangerous in that they occur without warning; move at intense speeds; and can tear out trees, destroy roads and bridges, and wreck buildings. In cases of dam failure (e.g., the Johnston dam disaster of 1889, the Buffalo Creek dam disaster of 1972), the water can be especially destructive. In the aftermath of the Buffalo Creek disaster in which a dam in West Virginia collapsed, 224 children were evaluated using interviews, story telling, and projective measures. It was reported that most of the children who survived the flood experienced psychological distress. The two most significant predictors of impairment were the degree of disaster exposure and perceptions of family reactions (Newman, 1976).

Floods such as those that occurred in the Midwest during 1993 provide more time to prepare, because residents are aware of rising river levels. Sensations that may generate coping challenges include desolation of the landscape, the smell of sludge and sodden property, coldness and wetness, and vast amounts of mud. Most floods do not recede overnight, and many residents have to wait days or weeks before they can begin the cleanup. As noted by Feinberg (1999): "Flood waters sometimes take quite a while to recede and the extended agony of waiting to see what is left after your home has been under water for a month aggravates an exceedingly stressful emotional situation" (p. 134).

Relocation

The frequent need for disaster survivors to relocate also creates unique crisis problems. For example, it may contribute to social, environmental, and psychological stress experienced by disaster victims (Milne, 1977; Raid & Norris, 1996; Quarantelli, 1985). Research following three major disasters supports these observations. The first disaster was the Buffalo Creek dam collapse of 1972, which flooded 16 small Appalachian communities and left 4,000 people homeless (Quarantelli, 1985). The second was Cyclone Tracy, which struck Darwin in the Western Territory of Australia on Christmas Day 1974 and destroyed more than 60% of the community's homes (Milne, 1977). The third was Hurricane Andrew, which struck south Florida in August 1992 and left approximately 250,000 people homeless (Raid & Norris, 1996). The results of these studies indicated that relocation was associated with higher levels of ecological stress, crowding, isolation, and social disruption. For example, in the Hurricane Andrew study, families who were relocated and living in poor conditions fared worse than either nonrelocated families who lived under comparable conditions and other relocated families who lived under better conditions.

Parents' Reactions and Family Support

McFarlane (1987) addressed the adjustment of 805 5- to 12-year-old-children following the 1983 bush fires in Southeast Australia. He concluded that the overall adjustment of parents was found to be an important determinant in the adjustment of children, and the adjustment of the children in turn contributed to the overall adjustment of the family. In addition, McFarlane found that altered family functions, separation from parents after the fires, and ongoing maternal preoccupation with the trauma were more predictive of trauma symptomatology in children than was the level of exposure.

In families with parental conflict, children are left to cope with the effects of a disaster without the full attention or support of their parents. In a study of elementary school-age children, at 3, 7, and 10 months after Hurricane Andrew, low levels of perceived social support and marital conflict were related to posttraumatic stress symptomatology (La Greca, Silverman, Vernberg, & Prinstein, 1996; Vernberg, La Greca, Silverman, & Prinstein 1996; Wasserstein & La Greca, 1998). Thus, parents' reactions and family support following a natural disaster are important considerations in facilitating the coping of children.

Emotional Reactivity

Preliminary findings suggest that children with high levels of trait anxiety or high levels of trait negative affectivity are those children most likely to develop posttrauma symptomatology following a natural disaster (Lonigan et al., 1994). In studying children exposed to Hurricane Hugo (Lonigan et al., 1991), they found that strong negative affect during the hurricane was related to degree of exposure as was higher levels of trait anxiety. In another study supporting this conclusion, researchers examined risk and protective processes for posttraumatic stress reactions and negative sequelae following the Northridge Earthquake that struck the Los Angeles area. The findings suggested that children who had a preexisting anxiety disorder prior to the earthquake were at greatest risk of developing PTSD symptoms (Asarnow et al., 1999).

Coping Style

It is important to examine children's coping following a natural disaster because coping responses appear to influence the process of adapting to traumatic events (Terr, 1989). Two studies in the 1990s examined how children cope following natural disasters. The first study evaluated children's coping following Hurricane Andrew using Kidcope, which is a brief checklist developed to assess the use of 15 different coping strategies by children and adolescents (Spirito, Stark, & Williams, 1988). The authors factor analyzed the instrument into four different coping styles (Vernberg et al., 1996) and labeled these styles: (a) positive coping, (b) blame and anger, (c) wishful thinking, and (d) social withdrawal. Three months after Hurricane Andrew, children reported using wishful thinking most frequently, followed by positive coping, social withdrawal, and blame and anger, respectively. Results suggested that the use of blame and anger as a way of coping might have the strongest negative ramifications for children's levels of distress following disasters.

The second study evaluated children's coping following the Northridge Earthquake (Asarnow et al., 1999). Using the Coping Responses Inventory (Moss, Cronkite,

BEST COPY AVAILABLE

Billings, & Finney, 1988), the following coping styles were identified: (a) active cognitive coping (11 items describing coping strategies that emphasized active thought about the stressor), (b) active behavioral coping (13 items describing specific actions that could be used to cope), and (c) avoidance coping (8 items describing attempts to avoid thinking or dealing with the stressor). Findings suggested that children with more PTSD symptoms tended to rely on cognitive and avoidance strategies to cope with intrusive images and thoughts about the earthquake.

Developmental Considerations

Loss of trust in adults and concern about the disaster reoccurring are responses seen among youths exposed to traumatic events [National Institute of Mental Health (NIMH), 2000]. For example, Shelby and Tredinnick (1995), in discussing reactions to Hurricane Andrew, reported that children's anxieties about the storm seemed to be increased by loss of the illusion of parental omnipotence. After the initial stress of the storm, many youngsters found their parents unable to provide them with basic necessities. In addition, many children experienced their parents losing emotional control. Shelby and Tredinnick concluded that the loss of confidence in their parents' ability to control events left children feeling vulnerable to life dangers that they were previously shielded from by parental assurances.

Preschool-Age Children

In a study of preschooler's reactions 14 months after Hurricane Hugo, Swenson et al. (1996) found that a small percentage of preschool youngsters who had experienced the hurricane continued to play hurricane games (9%), showed fear of storms (14%), and talked about the hurricane in conversation (9%). In addition, the preschoolers showed significantly greater problems with withdrawal or anxiety and general behavioral problems.

Elementary-Age Children

It is not uncommon for children ages 6- to 11-years to have nightmares, sleep problems, irrational fears, and irritability following a natural disaster (NIMH, 2000). Elementary-age children may show extreme withdrawal, disruptive behavior, and have difficulty paying attention. Outbursts of anger and getting into fights with their peers are common. Young children may complain of stomachaches or headaches that have no medical basis. Moreover, depression, anxiety, and emotional numbing are often present (NIMH, 2000). Specific fears may also occur, including fear of the dark, fear of being left alone, fear that something bad will happen to their family members, fear they will be left alone or separated from their family, and fear that they caused some part of the disaster (La Greca, Vernberg, Silverman, Vogel, & Prinstein, 1994).

Middle and High School Age Youths

In a study of Nicaraguan adolescents' reactions after Hurricane Mitch, it was found that youths in heavily affected areas experienced chronic and severe levels of posttraumatic stress and depressive symptoms (Goenjian, Molina, Steinberg, & Fairbanks, 2001). These researchers reported accumulating evidence that these sequelae have adverse effects on adolescents' future development, economic productivity, health, academic achievement, and the stability they bring to marriage and family life (Goenjian et al., 2001).

Gender Considerations

In studies using large samples, boys have typically been found to be less symptomatic than are girls following natural disasters (Green, Korol, Grace, & Vary, 1991; Lonigan et al., 1991; Shannon et al., 1994). However, Shaw, Applegate, and Schorr (1996) found that 21 months after Hurricane Andrew there continued to be increased indices of psychopathology for both boys and girls, with boys tending to display externalizing symptoms and girls tending to display internalizing symptoms. Considering the paucity of research examining gender differences in children's responses following a natural disaster, conclusions remain tentative and further research is warranted.

Cultural and Ethnic Considerations

Few studies have systematically examined cultural and ethnic differences in response to natural disasters. Those studies that have examined youths exposed to natural disasters have used different methodologies and reported contradictory results (Garrison et al., 1995; Lonigan et al., 1991; Shaw, Applegate, Tanner, & Perez, 1995). For example, in one study (Vernberg et al., 1996), no differences between ethnic groups occurred at 3 months (when controlling for hurricane exposure), but at 7- and 10-months posthurricane, Hispanic and African-American children reported greater PTSD symptoms than did Caucasian children (La Greca et al., 1996). However, in another study of the same hurricane (Jones, Fray, Cunningham, & Kaiser, 2001) no ethnic group differences were found.

An emerging area of research investigates the degree of family support and parental conflict as a moderator of children's adjustment following a natural disaster (Wasserstein & La Greca, 1998). It has been documented that when problems occur in middle-class American Caucasian families, assistance and support from the school system is accepted or encouraged by family members. In contrast, Hispanic families often rely on intergenerational support, because many generations of family members participate in the upbringing of children. In fact, close family support was more predictive of overall well-being for Hispanic children than for African-American children (Levitt, Guacci-Franco, & Levitt, 1993). Following Hurricane Andrew, Wasserstein and La Greca (1998) reported that high parental conflict was related to more PTSD symptoms in children; however, this was qualified by ethnicity. For Hispanic children, parental conflict was positively correlated with PTSD symptoms. In addition, among those children in families with high parental conflict, Hispanic children reported more PTSD than did white children.

Crisis Response Following a Natural Disaster

All schools must have in place a crisis response plan and a crisis response team (see Chapter 14, School Crisis Preparedness, in this volume; Brock, Sandoval, & Lewis, 2001; Poland & McCormick, 1999). The plan must address how to respond to a natural disaster and clarify the roles and responsibilities of each staff member. Faculty and staff must be informed of the protocol to follow when a disaster occurs. A crisis response procedural checklist is highly recommended (see Brock et al., for an example of a crisis response procedural checklist and a list of 17 procedures to follow, pp. 95-96). This checklist can guide the crisis response team through all phases of the recovery. It needs to be emphasized that using a procedural checklist assumes that all members of the crisis team have been adequately trained and engaged in crisis preparedness activities before a natural disaster occurs.

Actions to Take Prior to Opening School

Lazarus and Gillespie (1996) interviewed principals, assistant principals, crisis intervention specialists, and coordinators of psychological services one year after Hurricane Andrew to determine how they coped and what they learned. The following summarizes the most essential actions school system administrators should take prior to the opening of school following a natural disaster.

Establish alternative means of communication. When natural disasters occur, traditional communication services (e.g., telephones, cellular phones) may be interrupted or destroyed. Therefore, devising effective alternative means of communication is essential because communication is necessary immediately following a natural disaster. The principal and the members of the school crisis team need to make certain they have a way to make contact with each other, all faculty members, and other staff personnel, for example, by agreeing on a given location where important messages will be posted or by distributing two-way radios with district crisis emergency kits in the event that traditional communications systems are unavailable.

Delineate a process for faculty to contact the crisis response team and their students. All school staff should contact a previously designated phone number(s) or person(s) to report their condition. This step is made necessary by the possibility that staff members may be displaced by the disaster and if the crisis team attempts to contact them they may appear to be missing. It is also recommended that all faculty contact their students to determine if and how they were affected by the disaster.

Conduct a quick assessment of the damage and make appropriate accommodations. Administrators and faculty should inventory the damage caused to their school and classrooms. Structural damage will result in a shortage of instructional space, so other accommodations may be necessary. Arrangement with nearby schools in advance may be established as part of the crisis response plan for natural disasters.

Determine the level of response required. A tornado that partially destroys one school campus will require a different level of assistance than an earthquake or hurricane that destroys a number of school facilities. School superintendents, in consultation with districtwide school crisis teams, should determine what type of mental health assistance is necessary. It is better to arrange for such mutual aid assistance before school opens than to find out later that assistance was needed and was not requested.

Address the emotional and survival needs of faculty and staff. Crisis intervention must be made available to all affected faculty and staff prior to the opening of school. It must be acknowledged that, if staff members have lost their homes, they will have to seek new lodging and will be under enormous stress. In addition, it is likely that arranging transportation for themselves and their children will be most difficult. Following Hurricane Andrew, for example, it was not unusual for staff to have to wake up at 3:30 AM to get their children to school and themselves to work.

Designate a liaison to provide feedback to the media. This step will provide rumor control and consistency of shared information. Media can enlighten the community on the impact and needs of the school following a natural disaster and help establish partnerships between citizens and schools. For example, unless properly directed, schools may end up with supplies and clothes they do not need and cannot store, while their real needs may go unmet. The school can serve as an up-to-date information center and provide accurate information on community resources and school operations.

Identify staff needs and provide assistance. As mentioned, natural disasters may generate problems associated with finding food, clothing, and shelter. These needs should be identified and assistance provided. For example, following Hurricane Andrew the staff at one elementary school brought FEMA personnel into the school to help staff members most severely affected by the storm. A Teachers-Helping-Teachers bulletin board was also initiated that listed the needs of staff members (which ranged from babysitting or a place to do laundry to transportation or a place for storing household goods, food, and clothing). In addition, a list was posted with names of volunteer staff members willing to help in specific areas. A retired attorney based at the school provided free legal advice related to insurance and housing (Del Valle, Lazarus, & Madique, 1996).

Contact all families needing help. In addition to helping staff, outreach to students' families should also be undertaken. For example, parent teacher associations and/or student councils may provide gift certificates for either food or household items. This outreach will provide crisis intervenors with an opportunity to connect with some of the most severely affected students and families. Following Hurricane Andrew, contacts enabled school mental health staff to debrief parents and provide educational materials and suggestions for coping in the aftermath. Given that a caring, stable parent is an important influence on a child's adjustment following a catastrophe (Benedek, 1979), it is essential to support the families of students. In addition, this outreach permits the school mental health professional to evaluate the family stressors and determine the child's level of risk.

Actions to Take on the First Day of School and Beyond

Greet every child in the building. The principal should visit every classroom and express concern for each student and their families. A heartfelt letter written by the principal and distributed to each student and their families may provide important information and facilitate healing.

Conduct a group crisis intervention (debriefing) in every classroom. The purpose of this intervention is to enable all students to make some sense of the disaster. The process provides an opportunity for all students to express their reactions, have their feelings validated, and predict and prepare for the future. The group crisis intervention encourages students to develop effective means of coping, find commonalties of reactions among all classmates, and develop support networks among students (see Chapter 20, Group Crisis Intervention, for a more complete description of this process).

Engage in postdisaster activities that facilitate healing. Researchers at the University of Miami and Florida International University (La Greca et al., 1994) developed a manual for professionals working with elementary school children following a natural disaster. Activities in this manual emphasize three key components supported by the empirical literature: (a) exposure to discussion of disaster-related events, (b) promotion of positive coping and problem-solving skills, and (c) strengthening of children's friendship and peer support. Table 1 provides further discussion of these components.

Encourage creative instructional methods using lessons learned in the aftermath. In dealing with lessons from disasters, teachers can use real-life examples to teach about math, weather, geography, geology, history, politics, social studies, psychology, and literature. A crisis can open individuals to new learning, and teachers may be presented with the ultimate teachable moment (Lee, 1999).

Identify students who are high risk and plan interventions. These students include those who: (a) had a high level of exposure, (b) who thought they might die during the disaster, (c) were physically injured, (d) witnessed grotesque destruction, (e) suffered significant loss, (f) are grieving for victims, (g) relocated following the disaster, (h) had preexisting anxiety disorders or other mental health problems, (i) had inadequate parental support, or (j) used inadequate coping strategies. Interventions may include individual counseling, small group counseling, or family therapy (see Chapters 20, Group Crisis Intervention, and 21, Individual Crisis Intervention). As a result of

Table 1

Activities That Promote Healing Following a Natural Disaster

Exposure to a discussion of disaster-related events

Children need an opportunity to discuss their experiences in a safe, accepting environment. Activities need to be provided that enable children to discuss their experiences and may include a range of methods (both verbal and nonverbal) and incorporate varying modalities (e.g., drawing, stories, audio and video recording).

Promotion of positive coping and problem-solving skills

Activities should teach children how to apply problem-solving skills to disaster-related stressors. Children should be encouraged to develop realistic and positive methods of coping that increase their mastery over anxiety and to identify which strategies fit with each situation.

Strengthening of children's friendship and peer support

Children with strong emotional support from others are better able to cope with adversity. Children's relationships with peers can provide suggestions for how to cope with difficulties and can help decrease isolation. In many disaster situations, friendships may be disrupted because of family relocations. In addition, parents may be less available to provide support to their children because of their own distress and their feelings of being overwhelmed. Therefore, it is important for children to develop supportive relationships with their teachers and classmates. Activities may include asking children to work cooperatively in small groups in order to enhance peer support.

Note
Adapted from La Greca et al. (1994).

the group crisis intervention and by maintaining close contact with teachers and parents, the school crisis response team can determine which students need counseling services. A mechanism also needs to be in place for self-referral of students.

Secure administrative support. Following a disaster, extra administrators at the school site(s) may be needed. For example, one school, following a series of tornadoes, made use of a recently retired principal and arranged for another principal to be assigned to the school for temporary duty. This support helped the principal to rally the staff and students to meet postdisaster challenges and to serve as the media spokesperson (while other administrators handled other routine administrative functions).

Secure mental health support. Although more than enough caregivers are often willing to provide support during the immediate aftermath of a natural disaster, long-term services may be lacking. Thus, it will be important to include provisions in any crisis response plan for providing such long-term assistance.

Debrief all members of the crisis response team. All crisis response team members need an opportunity to process the crisis response. Providing crisis intervention is emotionally draining. As Pat Howard reported, after she provided crisis intervention following Hurricane Andrew, "As a member of the State Crisis Response Team, when I surveyed the damage of Andrew and saw the wreckage, I felt like I went to someone's funeral and I didn't know that person, like I entered someone else's tragedy ... And when I left I didn't want to leave and felt guilty when I did" (Lazarus & Howard, 1993, p.18).

Summary

This chapter has reviewed issues associated with specific natural disasters (e.g., hurricanes, earthquakes, tornadoes, floods); developmental, gender, and cultural considerations related to natural disasters; and practical suggestions for crisis response following a natural disaster. In particular, this chapter has emphasized the impact of natural disasters on children and what we have learned from previous incidents about important influences on children's coping following a natural disaster. Current research emphasizes teaching effective coping strategies, fostering supportive relationships, and helping children process their emotions to facilitate healthy adjustment in the aftermath of a natural disaster. It is clear that collaboration between the school crisis response team and an assortment of community, state, and federal organizations and agencies is necessary to respond to the many needs of children, families, and communities in the wake of natural disasters. In addition, previous incidents provide insights regarding response activities and necessary planning and preparation to enhance a school's immediate response following a natural disaster. Healing in the aftermath of a natural disaster takes considerable time; however, advanced preparation and planning will enhance the immediate response and facilitate subsequent coping and healing. It is essential that schools prepare for potential natural disasters.

References

Asarnow, J., Glynn, S., Pynoos, R. S., Nahum, J., Gunthrie, D., Cantwell, D. P., & Franklin, B. (1999). When the earth stops shaking: Earthquake sequelae among children diagnosed for pre-earthquake psychopathology. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 1016-1023.

Benedek, E. (1979). The child's rights in times of disaster. *Psychiatric Annals*, 9, 58-61.

Bloch, D. A., Silber, E., & Perry, S. E. (1956). Some factors in the emotional reaction of children to disasters. *American Journal of Psychiatry*, 113, 416-422.

Bolton, D., O'Ryan, D., Udwin, O., Boyle, S., & Yule, W. (2000). The long-term psychological effects of a disaster experienced in adolescence: II: General psychopathology. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 41, 513-523.

Brock, S. E., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Del Valle, P., Lazarus, P. J., & Madique, A. (1996). Interventions in the aftermath of a natural disaster: One school's story. *Crisis Management in the Schools*, 2, 2-4.

Feinberg, T. (1999). The midwest floods of 1993: Observations of a natural disaster. In A.S. Canter & S.A. Carroll (Eds.), *Crisis prevention & response: A collection of NASP resources* (pp. 223-239). Bethesda, MD: National Association of School Psychologists.

Garrison, C. Z., Bryant, E. S., Addy, C. C., Spurrier, P. G., Freedy, J. R., & Kilpatrick, D. C. (1995). Post-traumatic stress disorder in adolescents after Hurricane Andrew. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34, 1193-1201.

Green, B. L., Korol, M., Grace, M. C., & Vary, M. G. (1991). Children and disaster: Age, gender and parental effects on PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30, 945-951.

Goenjian, A .K., Molina, L., Steinberg, A. M., & Fairbanks, L. A. (2001). Post traumatic stress and depressive reactions among adolescents after Hurricane Mitch. *American Journal of Psychiatry*, 158, 788-794.

Jones, R. T., Fray, R., Cunningham, J. D., & Kaiser, L. (2001). The psychological effects of hurricane Andrew on ethnic minority and Caucasian children and adolescents: A case study. *Cultural Diversity and Ethnic Minority Psychology*, 7, 103-108.

La Greca, A. M., Silverman, W. K., Vernberg, E. M. Prinstein, M. J. (1996). Symptoms of posttraumatic stress in children following Hurricane Andrew: A prospective study. *Journal of Consulting and Clinical Psychology*, 64, 712-723.

La Greca, A .M., Vernberg, E. M. Silverman, W. K., Vogel, A. L.,& Prinstein, M. J. (1994). *Helping children prepare for and cope with natural disasters: A manual for professionals working with elementary age children*. Department of Psychology, University of Miami.

Lazarus, P. (1993). Lessons learned in the war zone. NASP *Communiqué, 22*(3), 3-5.

Lazarus, P. J., & Gillespie, B. (1996). Critical actions in the aftermath of natural disasters. *The School Administrator*, 53(2), 35-36.

Lazarus, P. J., & Howard, P. (1993). The state crisis response team: A humble and necessary beginning. NASP *Communiqué, 21*(6), 18-20

Lazarus, P. J., & Jackson, J. (1993). When the walls come tumbling down: Crisis issues following hurricane disasters. NASP *Communiqué, 21*(7), 16-18.

Lee, O. (1999). Science knowledge, world views, and information sources in social and cultural contexts: Making sense after a natural disaster. *American Educational Research Journal, 36*, 187-219.

Levitt, M. J., Guacci-Franco, N., & Levitt, J. L. (1993). Convoys of social support in childhood and early adolescence: Structure and function. *Developmental Psychology, 29*, 811-818.

Lonigan, C. J., Shannon, M. P., Finch, A. J. Jr., & Daugherty, T. K. (1991). Children's reaction to a natural disaster: Symptoms severity and degree of exposure. *Advances in Behavioral Research and Therapy, 13*, 135-154.

Lonigan, C. J., Shannon, M. P., Taylor, C. M., Finch, A. J., & Sallee, F. R. (1994). Children exposed to disaster: II. Risk factors for the development of post-traumatic symptomatology. *Journal of the American Academy of Child & Adolescent Psychiatry, 33*, 94-105.

McFarlane, A. C. (1987). Post traumatic phenomena in a longitudinal study of children following a natural disaster: The longitudinal effects of post-traumatic morbidity. *Australian New Zealand Journal of Psychiatry, 21*, 210-218.

Milne, G. (1997). Cyclone Tracy: I. Some consequences of the evacuation of adult victims. *Australian Psychologist, 12*, 39-54

Moss, R. H., Cronkite, R. C., Billings, A. G., & Finney, J.W. (1988). *Health and daily living form*. Palo Alto, CA: Social Ecology Laboratory.

National Center for Post Traumatic Stress Disorder. (2000). *The September 1999 earthquake in Taiwan and post-traumatic stress. A National Center for PTSD fact sheet.* White River Junction, VT: Author. Available online: www.ncptsd.org

National Institute of Mental Health. (2000). *Helping children and adolescents cope with disasters: Fact sheet.* Available online: www.nimh.nih.gov

Newman, C. (1976). Children of disaster: Clinical observations at Buffalo Creek. *American Journal of Psychiatry, 133*, 306-312.

Poland, S., & McCormick, J .S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Prinstein, M. J., La Greca, A. M., Vernberg, E. M., & Silverman, W. K. (1996). Children's coping assistance: How parents, teachers, and friends help children cope after a natural disaster. *Journal of Clinical Child Psychology, 25*, 463-475.

Quarantelli, E .L. (1985). Social support systems: Some behavioral patterns in the context of mass evacuation activities. In B. T. Sowder (Ed.), *Disasters and mental health: Selected contemporary perspectives* (pp. 123-136). Rockville, MD: National Institute of Mental Health.

Raid, J. K., & Norris, F. H. (1996). The social influence of relocation on the environmental, social, and psychological stress experience of disaster victims. *Environment and Behavior, 28*, 163-182.

Shannon, M. P., Lonigan, C. J., Finch, A. J., & Taylor, C. M. (1994). Children exposed to disaster. I: Epidemiology of post traumatic symptoms and profiles. *Journal of the American Academy of Child & Adolescent Psychiatry, 33*, 80-93.

Shaw, J. A., Applegate, B. A., Tanner, S., & Perez, D. (1995). Psychological effects of Hurricane Andrew on an elementary school population. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1185-1192.

Shaw, J. A., Applegate, B., & Schorr, C. (1996). Twenty-one month follow up of children exposed to Hurricane Andrew. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 359-366.

Shelby, J. S., & Tredinnick, M. G (1995). Crisis intervention with survivors of natural disaster: Lessons from Hurricane Andrew. *Journal of Counseling and Development, 73*, 491-505.

Spirito, A., Stark, L. J., & Williams, C. (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology, 13*, 555-574.

Swenson, C. C., Saylor, C. F., Powell, M. P., Stokes, S. J., Foster, K. Y., & Belter, R. W. (1996). Impact of a natural disaster on preschool children: Adjustment 14 months after a hurricane. *American Journal of Orthopsychiatry, 66*, 122-130.

Terr, L. C. (1989). Treating psychic trauma in children: A preliminary discussion. *Journal of Traumatic Stress, 2*, 3-20.

Vernberg, E. M., La Greca, A. M., Silverman, W. K., & Prinstein, E. M. (1996). Predictions of posttraumatic stress symptoms in children after Hurricane Andrew. *Journal of Abnormal Psychology, 105*, 237-248.

Wasserstein, S. B., & La Greca, A.M. (1998). Hurricane Andrew: Parent conflict as a moderator of children's adjustment. *Hispanic Journal of Behavioral Sciences, 20*, 212-224.

Young, M. A. (1997). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

Zenere, F. J. (2001, May). Tremors of trauma: Responding to the El Salvador earthquakes. NASP *Communiqué, 29*(7), 10-11.

Zenere, F. J., & Lazarus, P. J. (1999). Winds of terror. Children's responses to hurricane and tornado disasters. In A. S. Canter & S. A. Carroll (Eds.), *Crisis prevention and response: A collection of NASP resources* (pp. 223-229). Bethesda, MD: National Association of School Psychologists.

23

危機

Responding to a Sudden, Unexpected Death at School: Chance Favors the Prepared Professional

Shane R. Jimerson, Ph.D.
University of California, Santa Barbara

Leland C. Huff, M.S.
Huntington Beach Union High School District (Huntington Beach, CA)

A 6-foot, 260-pound, 17-year-old River View High School junior had just completed warm-up sprints before beginning practice for the semifinal game of the state football championship. Without a word, he dropped to one knee and then fell to the ground. His teammates, knowing Brad always liked to clown around, started to laugh. Soon they realized this time was no joke. They yelled for the trainer. In a few seconds, Brad was lying on his back with only a faint pulse. Then there was none. CPR was administered, but there was no response. An Emergency Medical Technician unit stationed across the street from the field was summoned and arrived within five minutes. Brad was unresponsive. Paramedics transported him to the local hospital. On campus, the school day was over and students had gone home. On the football field, everything had come to a standstill. Players, coaches, and others were huddled together waiting anxiously for word of Brad's condition. The police chaplain had arrived and both the school principal and the school psychologist had joined the group. A trainer had left the field office and was approaching the crowd. His head was down. He stopped, looked up, and said: "Brad is dead."

A sudden, unexpected death on campus is estimated to occur nearly every week in the United States (U.S. Department of Education, 1999). Fortunately, the incident described above occurred in a school that had prepared in advance by forming a crisis response team to respond to the needs of students following such tragedies. A death occurring at school presents unique issues for school mental health professionals and other educators attempting to coordinate a response to the loss and grief experienced by students, families, and staff. In addition, many developmental and cultural considerations influence crisis intervention procedures.

Preparations for responding to the aftermath of any crisis should include a comprehensive, yet flexible, plan that takes into account a school's diverse populations. Although many practical considerations are addressed in the development of a crisis response plan, often such plans and responses overlook the unique needs of those who are affected. The efficacy of intervention efforts will likely be positively influenced by taking time to address a few of these special considerations, including the developmental level of the students, the diversity of the student population and associated cultural considerations, and students with special needs.

Unique Crisis Issues

A variety of unique crisis issues must be addressed by crisis intervenors who confront a sudden and unexpected death. These issues include: (a) context of the death, (b) unique needs of special populations, (c) immediate intrapersonal adjustments, (d) changes in meaning systems, (e) the experience of grief and bereavement, and (f) the complexities of a traumatic loss.

Context of the Death

It should be recognized that the cause of death will influence bereavement. Worden (1991) categorizes death into four groups: natural, accidental, suicidal, and homicidal. Sudden and unexpected deaths are likely to have the greatest impact on grief (Worden, 1991). In addition, a sudden death, such as Brad's death, uniquely impacts the process of grieving because of the unavailability of information related to the cause of death. The absence of information regarding the cause of death may prolong the period of grieving and inhibit the process of recovery. Furthermore, for most students, the school is perceived as a safe and secure setting. The school is not a setting where death is expected to occur, and most teenagers do not view death as something that will occur to them. Thus, a sudden, unexpected death at school is likely to be especially salient for friends and peers. Schools must be prepared to provide appropriate support services for all students, teachers, and staff following a sudden, unexpected death on a school campus.

Special Needs Youths

Typically, throughout their youth, individuals develop increasingly mature coping responses. These include practical, emotional, and cognitive coping strategies (Hoffman, Levy-Shiff, Sohlberg, & Zarizki, 1992). Some students, however, may be more vulnerable following a crisis of this nature because of their unique developmental issues. Students who have special needs, those with emotional disorders, and those with low self-esteem may require unique support following a crisis. Students who are placed in special education programs may need additional supports to deal with the loss (Lavin, 1998).

Because of the disruptions experienced in their development, the coping processes of such individuals may be less mature, and there is a greater likelihood that they might deal with the death of a classmate in a manner similar to that of a younger child. For instance, during the adolescent years, there is usually an increased ability to think abstractly, anticipate future events, construct hypotheses, and evaluate consequences (Phelps & Jarvis, 1994). These skills may be less developed among special needs students. It has been suggested that providing appropriate response services to these children has received relatively little attention because the task involves a type of double taboo: death and developmental disability (Harper & Wadsworth, 1993).

River View High School, where the sudden death occurred, has a population of 2,800 students. Of those, 240 are students with special needs. Of primary importance is to establish an environment for all students that provides safety and security and reestablishes routine and equilibrium. Doing so for special needs students may require special efforts.

Intrapersonal Adjustments

Sudden and unexpected death is especially difficult because there has been no time to prepare for the loss. Because these types of loss occur without warning, individuals have little time to make cognitive and intrapersonal adjustments. Adolescence is typically a period of many changes, new situations at school, new relationships, and new responsibilities (Santrock, 1998). The experience of a sudden unexpected death of a peer adds yet another issue to cope with during the many changes of adolescence. Grief reactions may therefore be further complicated or delayed as youths process this new information that a peer has died.

Following a sudden, unexpected death there are many immediate changes in meaning systems. For instance, the event redefines the survivor's place in the world. Friends of the deceased can no longer define themselves as someone's friend or a teammate of the student; these relationships are altered to the past tense. Thus, there are typically many forced changes in meaning systems following the death of a student at school. When a sudden loss occurs without warning, individuals are typically unable to comprehend reality. Essentially, individuals are thrown into a conflict between the world the way it was, the way they hoped it would be, and the way it suddenly is.

Grief

It is important to understand that, unlike the crisis state, grief and mourning are likely to last for years (Worden, 1991). Students are likely to experience assorted reactions across transitions through developmental phases, and grieving is a process that will likely be reexperienced in some new way. In general, educational professionals should be sensitive to the effects of loss across development. If there is a sudden, unexpected death at school, the staff must be aware that many of the students will continue to grieve for years, and appropriate support should be made available.

Traumatic Loss

Students may also experience psychological trauma following a sudden, unexpected death at school. In general, the combination of trauma and bereavement may prolong symptoms common to both (McCann & Pearlman, 1990). Following a sudden death, some students may be traumatized, which may lead to emotional numbing or denial that may interfere with the experience of common grief reactions. Some students deeply impacted by the loss may avoid coming to school because the physical setting may serve as a reminder of the death (Klicker, 2000).

Developmental Issues

There are important developmental considerations when working with bereaved youths. If the loss involves an unexpected death such as that of a peer, the experience is further complicated in its emotional, cognitive, psychological, and behavioral considerations. Considering the above scenario, there will likely be a variety of grief responses among high school students. Variation is influenced by several developmental dimensions, including emotional and cognitive development and the importance of peers.

Emotional and Cognitive Development

When children and adolescents encounter death, grief responses and mourning are greatly affected by their emotional and cognitive development, including their understanding of death concepts. Most children younger than 10 years do not understand key components of the death concept (e.g., universality, irreversibility, nonfunctionality, and causality). Research suggests that around age 10, children begin to understand each of these components of the death concept, and most authorities on this topic suggest that children develop realistic death perceptions by this age (Anthony, 1972; Grollman, 1967).

Preadolescents and adolescents (roughly 10- to 18-years-old) have a more mature view of death and understanding of its irreversibility, universality, causality, and nonfunctionality. Although they typically have an "adult" understanding of death, adolescents commonly perceive themselves as invincible, invulnerable, and immune to the laws that apply to others (Arnett, 1992; Elkind, 1976). Often adolescents consider death as " … something that may occur in their lives—but at such a distant future it is inconceivable" (Young, 1998, p. 30). In addition, teenagers often romanticize death. Because of the continued exposure to death through movies and television, perceptions of the finality of death and the experience of dealing with such loss are jaded, and adolescents may not understand how difficult it can be to cope with death (Grief Resource Foundation, 1990).

High school students' grief experience may vary throughout their adolescent development, and they are likely to display a wide array of grief responses (Fleming &

Balmer, 1996; Oltjenbruns, 1996). The impact of a sudden, unexpected loss is often intense, and most adolescents are likely to experience sadness, shock, disbelief, surprise, anger, numbness, fear, guilt, and confusion (Oltjenbruns, 1996; Schachter, 1991). The death of a peer during adolescence "can be especially profound, due to the fragility of the youthful ego and the intense relationships adolescents have with their friends" (McNeil, Silliman, & Swihart, 1991, p. 133). In addition, while most adolescents will have an adultlike cognitive understanding of basic death concepts, few have experience coping with a sudden, unexpected death.

The Importance of Peers

An important consideration for the adolescent population is that peers become increasingly important. Teens spend a great deal of time with peers (Santrock, 1998). Given the importance of peer relations during adolescence, the death of a peer is especially salient (O'Brien, Goodenow, & Espin, 1991; Oltjenbruns, 1996; Podell, 1989). Appreciating this developmental characteristic, an appropriate response to the death of an adolescent should provide special attention to the close friends and peers of the deceased youth. Developmental research also reveals that older adolescents spend more time with peers than with parents (Santrock, 1998). When combined with the natural reluctance to engage in discussions with parents, this observation points to the value of peer support groups.

Cultural Diversity

The diversity that exists in many schools and communities is an important consideration in designing and providing an appropriate response to address needs. Intervention strategies need to be appropriate for different groups and individuals and need to consider cultural and spiritual diversity (Grabowski & Frantz, 1993; Oltjenbruns, 1991). In addition to the discussion of cultural considerations in crisis intervention provided in Chapter 15, resources are available to assist with understanding various perspectives on death and grief (e.g., Doka & Davidson, 1998). The following section discusses some important considerations at River View High School related to working with diverse populations. It will describe the beliefs associated with various religions, their views and concepts of death, and the process of grieving that may differ among cultures.

Because individuals and groups from diverse cultural backgrounds may respond differently, crisis response plans must be tailored to the community and students they serve (Doka, 1998). Burak (1987) emphasized that an "understanding of and respect for the differences inherent in each culture are needed for rapid, effective, and sensitive treatment of emergency situations" (p. 23). The unique characteristics and demographics of the school and the community must be considered when planning a comprehensive crisis response plan (Young, 1998). Essential considerations are the ethnic and cultural groups within the school community, preparing a plan that is culturally relevant, and preparing resources in the relevant languages. Crisis response will be enhanced when responders who are a part of the community and its different ethnic and cultural groups are involved in service delivery.

Using as an example the scenario at the beginning of this chapter, nearly half (49%) of the River View High School students are nonwhite. Of that group, nearly two-thirds are Asian. The largest population of Asian students is Vietnamese. A detailed review of cultural considerations for all ethnic groups at the school is beyond the scope of this chapter; however, examples of some of the cultural characteristics to consider when preparing a crisis response plan are presented below.

Vietnamese

The dominant religion of Vietnam is Buddhism (Hassan, 1985). In addition, as Catholicism was introduced to Vietnam during the French rule, this religious orientation is also common. According to Buddhist doctrine, death is not the end to existence it is just closing one chapter. The next chapter is opened immediately. There is death and then rebirth. Buddhists often believe that life is a period of suffering after which they will be reincarnated. The Vietnamese have interpreted this to mean that life is investment and repayment. They invest for their future life and repay for their previous life. In the cycle of life, one of the most important factors is suffering. People are willing to suffer both mentally and physically. Being sensitive to such beliefs is important when responding to a death on campus. There are many variations in commemorative activities and rituals honoring the deceased. Being aware of these variations and preparing in advance will enhance a response following an incident such as the scenario previously described.

From their Buddhist faith, the Vietnamese family recognizes a liaison between living family members and the spirits of the dead as well as those not yet born. To the Vietnamese people, family is the most important unit and is considered as a mini-commune where all social and religious services (e.g., ancestor worship, counseling, funeral rituals, and childcare) are conducted (Vuong, 1976). Dutiful devotion and conformist respect are considered a significant factor in Vietnamese family life. Children from the age of four are raised to treat their parents with politeness, obedience, and respect (Phung, 1979). Because of strict discipline, Vietnamese youths often appear shy and passive when compared with most American teens. They are taught rules that prevent them from interfering or interrupting an older person's conversation, and they may be less likely to share their feelings or thoughts following an incident on campus. They also consider looking straight into the eye of another, especially an adult during a conversation, to be impolite. Each of these cultural differences warrants consideration when responding to an incident on campus.

The Vietnamese student population at River View High School is representative of similar school communities across the United States. The parents of the students were born in Vietnam and many have attempted to preserve the values, traditions, and beliefs of their culture while their children have been exposed to the social environment of Western culture. This situation has created conflict in many Vietnamese homes, and many parents feel powerless and stressed. The effort to maintain cultural values frequently results in an inclination to reject Western approaches to treatment. As a result, attention to these cultural considerations, especially when communicating with Vietnamese families, may facilitate the implementation of important support services.

Japanese

Not all the Asian students at River View High School are Vietnamese. Despite a tendency to cast all Asian cultures into a single entity, it is important to recognize that there is great religious and cultural diversity in Asian countries. In Japan, the primary connection most people have to Buddhism is through funeral rituals and rituals honoring family ancestors (LaFleur, 1992; Nara, 1995; Reader, 1991; Smith, 1974). For instance, one Japanese ritual in response to death is to perform a series of rituals that may last between 33 and 50 days (Klass, Silverman, & Nickman, 1996). During the first 49 days, the rituals transform the deceased to a new Buddha. This transformation is associated with restructuring of the relationship between the deceased and the bereaved (Smith, 1974). Another common Japanese event related to death is the Bon Festival. It is believed that the dead return to visit the living for three days during this summer event.

Chinese

Many Chinese religions blend Confucianism and Taoism, and often include some indigenous shamanistic traditions (Klass & Goss, 1998). In some regions of China, Buddhism is popular. Although funerals in Taiwan are generally held in a Buddhist temple and the family house, Chinese Americans often hold funerals at funeral homes and mortuaries. Traditional Buddhist or Taoist mourners often wear white clothes rather than black or dark colors to express their grief.

Other Cultural/Ethnic Considerations

Caucasian, Hispanic, and African American students at River View High School also warrant consideration because there will be variation among these groups (Barrett, 1995; Irish, Lundquist, & Nelson, 1993). For example, while the Roman Catholic faith is an important resource for many Hispanic students following a sudden death, Muslim and Baptist congregations are often helpful for African Americans (de Paula, Laganá, & Gonzalez-Ramirez, 1996; Locks & Boateng, 1996).

A review of available empirical studies yields no definitive research foundation providing specifics on cultural variations of mourning among adolescents; however, some books provide useful information from a sociological and psychocultural perspective (Doka & Davidson, 1998; Kalish & Reynolds, 1976; Lewis, 1969). Although being sensitive to cultural variations is important, as Klass and Goss (1998) remind us, "There is no 'Eastern' way of grieving or coming to terms with death, just as there is no 'Western' way" (p. 13).

Many similarities in grief responses appear to hold true across different cultural groups (Irish et al., 1993; Parkes, Laungani, & Young, 1997). For example, when Vietnamese students experience an unexpected death, their grief, shock, and disbelief is similar to that of other adolescents. Their existence as they knew it a day ago has changed in the same way. Although their religious and cultural beliefs may facilitate coping with a death, the loss of a classmate universally results in distress, sorrow, and grief. The experience of unexpected bereavement has many unique and specifically traumatic aspects, such as distress and disorientation (Genovese, 1992; Wenckstern & Leenaars, 1993).

The information discussed in this section highlights the importance of cultural considerations when working with diverse populations. Responding to a crisis where the traumatized are of a different culture is challenging. If crisis intervenors can focus on similarities, be sensitive to differences, and show respect for the people they serve, the challenge becomes manageable (Young, 1998). It is important to consider cultural and spiritual diversity in advance. Asking questions with sensitivity regarding students' beliefs and traditions before and following an incident will provide understanding, which is essential in offering appropriate support services.

Crisis Intervention

The response of school personnel, helping professionals, parents and other family members, community leaders, clergy, and others can facilitate healthy bereavement following an incident such as the one at River View High School. Collectively, these efforts have been termed "postvention" (Schneidman, 1981), which simply refers to all the activities and support that help survivors cope with a sudden loss. Metzgar (1994) recommends a systematic crisis management plan be prepared for "any situation that causes, or has the potential to cause, a disruption of normal functioning within the school community" (p. 20). This section focuses on the postvention efforts at River View High School.

The crisis response team at River View, through training, had been made aware of cultural considerations. For instance, training had addressed the fact that Buddhism is the primary religion in the local Vietnamese community. Further, it is difficult for the parents of many Asian students to accept Westernized approaches to dealing with emotional and psychological issues. Counseling is viewed as the responsibility of the family and occurs in the home. However, many River View families now find themselves in conflict with their "Westernized" children. The parents, perhaps more than the students, required consideration and respect for their culture.

The National Organization for Victim Assistance (NOVA) offers a useful framework and practical series of steps to develop and coordinate a crisis response team. The crisis response team at River View High School uses the protocol suggested by NOVA for a group crisis intervention (Young, 1998). This model addresses the critical event from a chronological perspective, recalling what happened at the time of the event, what occurred in the immediate aftermath, and what is expected to happen in the future. The model allows for participants to share those reactions, observations, and experiences that cut across cultural differences. It is suggested that the intent of the initial response is to address trauma experienced in a crisis, not to do psychological counseling, but to help students and staff deal with their shock and grief through discussion and empathic support (Hicks, 1990). Because of the emphasis on establishing a safe and secure environment following a loss, the NOVA model is especially useful during the first 72 hours following a sudden, unexpected loss at school.

The Asian American community's beliefs may conflict with Western ways of dealing with psychological and emotional issues. Furthermore, when individuals are in crisis it may be adding insult to injury to suggest services that imply the need for mental health assistance (Farberow & Frederick, 1978). Professionals responding to such an incident in the schools are encouraged to identify themselves as crisis responders or use other titles that do not imply mental health or psychological services. The use of terms such as crisis group, support group, or student assistance is also helpful. For students and staff who may need additional support services, referrals may be made to outside professionals.

At the high school level, one way of bridging the cultural and developmental gap is to include student representatives on the school crisis response team. Involving students in a crisis team is valuable (Metzgar, 1994). Besides providing additional resources, students are able to report observations of responses to interventions from the students' perspective and provide information regarding the emotional climate of the school. This valuable input provides the crisis team with information that can help modify the crisis response and provide services where they are most needed. It should also be noted that when students are involved in this way, the response must include appropriate training and professional support for these students so that they are not further traumatized in their efforts to assist the crisis response. The students participating in the crisis response efforts at River View High School have had American Red Cross training in providing emergency services. Furthermore, the adolescents' desire for control over their own world, coupled with their penchant for questioning adult authority and decision making, underlies the importance of involving trained students in the planning for a response following a sudden, unexpected death. Involving youths offers them a sense of ownership and empowers them to identify meaningful and constructive ways to express their emotions (Young, 1998). While the value of student involvement is evident, further research is necessary to determine the effects on students engaged in these efforts.

Two student groups at River View High School are included in the crisis response plan. Both are extracurricular clubs with faculty leaders. One of these student groups receives support and guidance from the County Human Relations Commission in an effort to reduce violence and help manage differences resulting from diversity among student groups on campus. The second group is the Red Cross Club. The large majority of students in this club are Asian, with most being Vietnamese. Members of this club participate in training programs offered by the American Red Cross. One program in particular, Youth in Emergency Services (YiES), has provided training in various aspects of crisis and disaster response. These students have become a valuable resource in providing a wide array of services and are particularly helpful in communicating with families and connecting with resources in the Asian community.

During the postvention efforts, student groups may assist the crisis team with clerical tasks such as delivering important messages to and from classrooms and the incident command center. When needed, they may also accompany distressed students from classrooms to the school "support center." If a distressed student is suicidal, it is necessary to have school personnel trained in dealing with suicidal youths available to accompany students and provide appropriate support. Following Brad's death, these Red Cross Club students made themselves available at 6:30 AM to ensure that any teachers or substitutes who were not at the faculty meeting received necessary information.

The first step in designing a response to a sudden, unexpected death at school is to ensure a safe and secure environment for all students. Proactive steps are taken to minimize the anticipated chaos resulting from news of the event spreading across the community and school the next day. Information is obtained, and the facts of the incident are verified by the professionals involved (police, coroner, school administrators). This information is communicated immediately and regularly to staff through faculty and staff bulletins, to students through classroom announcements, and to members of the school community through letters sent home with students. In addition, school personnel responsible for handling calls from the community are provided with information that can be read to those calling to inquire. The crisis plan mandates an assessment of the impact on the school, its staff, its students, and on the community. As the crisis team was convening to develop the details of a 48-hour response plan, the media were already spreading news of the event. Although proactive steps were being taken to minimize the anticipated chaos resulting from the event, an immediate response was needed to attend to the chaos and confusion occurring on the football field.

Elements of the Crisis Response Plan

A valuable first step is to consider the elements of the crisis plan that was developed, because this plan identified important response activities associated with the unique dimensions of this incident. Each element of the plan identified who, what, when, where, and how to address each important facet of the response. Those elements of the crisis plan specifically relevant to a sudden, unexpected death at school are presented in brief below.

Provide advance notification to faculty and staff. Notify both faculty and staff of the details of the incident before the next school day. This is especially important fol-

458

lowing a sudden, unexpected death because the faculty and staff need to be aware of the incident in order to prepare to lead class discussions when meeting with students the next school day. Teachers can be instrumental in helping students to cope with the loss, to defuse the impact of the trauma, and to help students regain cognitive control and understanding of the event (Young, 1998). Given that most students will learn of the incident at school the next day, this advance notification gives the faculty and staff a bit more time to personally process the information. Thus, they will be better prepared to provide a supportive presence to the students.

Hold an organizational meeting for faculty and staff. Schedule a meeting with teachers and staff in the morning prior to the opening of school. The morning meeting is an opportunity to provide additional details regarding the sudden, unexpected death. The teachers and staff will receive a reminder about everyone's role in the crisis response plan. In addition, all school personnel should be provided with necessary materials containing important information as described below. And finally, this meeting provides an opportunity to evaluate the impact the crisis may have had on the staff. There may be teachers who, because of their special relationship with the deceased, are unable to carry out their scheduled duties, and substitutes may be needed.

Contact the District Office for resources. Notify the District Office of a need for additional support personnel, because of the intensity and anticipated impact on the school and the community. The school will benefit from having professionals trained in crisis response and professionals trained to work with bereaved youths and adults. This step is very important because during the first week following the sudden loss, the number of individuals requiring professional support may exceed the capacity of the on-site school psychologists and counselors. Some schools will need to request that support personnel with appropriate training be available, as local school staff may not have been prepared to work with bereaved youths. In addition, school personnel and the resources of the school will be further stretched by the demands of the media, parents, and unsolicited volunteers.

Identify a support center and safe room. Identify a room for the "student support center" and a "safe room" for faculty and staff. The student support center is necessary for those students having a difficult time coping with the loss. Although many adolescents may have experienced a death of a family member, a grandparent, or close relative, the loss of an age-group peer is often associated with the loss of companionship, love, and personal support (Oltjenbruns, 1996). Furthermore, these rooms are important following a sudden loss because teachers or staff may also experience a difficult time coping with the loss, and having designated locations in the school will facilitate accessing support services. Professionals trained to work with grieving children and adults experiencing a sudden loss should staff these rooms.

Develop materials for faculty. Provide teachers with a fact sheet to read to students and guidelines on how to conduct classroom discussions for grieving students (see this chapter's Appendix A for sample letter, announcement and guidelines for classroom discussions). The role of the teacher is a critical component of the intervention plan given the unique circumstances associated with this tragedy. It bears repeating that a sudden, unexpected death, especially a nontraumatic death, does not provide many answers in a useful and timely way. Therefore, student reactions and emotions are expected to be intense.

Develop materials for parents. Prepare a packet for parents including a fact sheet, tips on how to help youths during grief, and information regarding the services being provided for students and parents on campus. For instance, following a sudden, unexpected loss: (a) it is important to allow youths an opportunity to ask questions and talk about the event both immediately following the incident and over the upcoming weeks and months; (b) youths need information addressing their questions that is honest and accurate in developmentally appropriate language they can understand; (c) grief reactions may include, denial, anger, sadness, anxiety, fear, confusion, inability to concentrate, difficulty sleeping, and guilt, all of which may affect school performance and behaviors at home and in the classroom; (d) grief is a normal response following a loss, but persistent or very intense grief responses may require attention from trained professionals; (e) it is especially important to be available, nurturing, and predictable in the days and weeks following the incident; and (f) school and community services should be delineated so that families may take advantage of these resources. (For additional information regarding appropriate information to communicate in a fact sheet see Chapter 32, Children's Grief, and the brief overview of Core Principles for Helping Grieving Children by Dr. Bruce Perry, which is available in the Chapter 23 Appendix B.)

Identify those most at risk. Identify within the first 24 hours, using a triage process, those most affected by this crisis, monitor their progress, and communicate with their families. Those most affected were easily identified within the first hour of the intervention. They were the football players who witnessed the incident; the coaches, especially those who treated Brad (unsuccessfully); and members of the varsity squad. In addition, other close friends were also identified and provided appropriate support.

Conduct staff debriefing sessions. Hold a staff debriefing at the end of the first day and regularly during the next few weeks, with faculty, staff, and group crisis intervenors, to identify strengths and weaknesses, get a feel for the "health" of the school, help identify students and staff in need of follow-up, and modify the plan if needed. Given the unexpected nature of the event described above, it is important to keep in mind that the health of the school will likely change during the days and weeks following the sudden death. Even the best crisis response plan will not account for all possible scenarios. Thus, these regular staff debriefings and check-up sessions will provide an opportunity to alter the plan or secure additional or specific support services as necessary.

Develop materials for the media. Provide information to the local media, including a fact sheet, tips on helping adolescents during grief, and information regarding services available on campus for students and families. Identifying common grief reactions that may occur following a sudden loss, such as shock, numbness, disbelief, denial, sadness, anger, and anxiety, can help reporters incorporate helpful information into their stories and help avert the sensationalism associated with the unsolved mystery of the death of an athlete. Having a list of services available at the school and, when appropriate, other resources in the community can also be very helpful.

Provide support services. Perhaps the most important element of the River View response plan was ensuring that the crisis support groups were available. Steps were taken to provide group crisis intervention procedures that were consistent with those established by NOVA (Young, 1998). Using the NOVA model, students and staff were helped to take the first steps toward reestablishing equilibrium and were given an opportunity to discover that their reality is very similar to others'. The procedures used in the group setting, although much more systematic and structured, are similar to those that teachers were encouraged to use in the classroom. School staff and group crisis intervenors alike were encouraged to provide students with factual information about Brad's death, avoiding euphemisms for death, and to provide a safe and secure environment. Teachers were informed that it was important to encourage teens to discuss their reactions, feelings, beliefs, and concerns regarding the crisis situation without insisting on this expression. The group intervention model also provides a medium that addresses the unique developmental characteristics of the adolescent. Myriad developmental issues complicate the grieving of the adolescent. While struggling for independence, adolescents often feel misunderstood and are faced with making difficult but important decisions regarding their future (Santrock, 1998). Often, they are looking for advice and comfort and do not know where to get it. Bereavement support groups can provide such a place (Baxter & Stuart, 1999).

An asset of the NOVA model is that it presents scaffolding for a group intervention that allows the expression of common experiences regardless of cultural or developmental considerations. Consequently, it is also a format that addresses other salient developmental characteristics of adolescence such as the phenomenon of egocentrism and their reluctance to discuss their personal feelings and experiences with their parents. This is to be expected and is consistent with their striving for independence. The experience of the group process addresses the issue of egocentrism by helping students gain an understanding that others may feel the same or may have very different experiences. Because there was no time to prepare for the loss, knowing that others are experiencing a variety of emotions and reactions is especially important. The cognitive and emotional reactions associated with the loss vary considerably from one individual to another. The process followed in the NOVA protocol allows the group participants to begin to recognize the commonality in the reactions to the incident and allows the process of rebuilding cognitive and emotional adaptive mechanisms to begin (Young, 1998).

Utilize community resources. Because the crisis plan at River View High School was developed using the Community Crisis Response Team model (Young, 1998), access to community mental health workers was also available. More importantly, the school identified two Vietnamese mental health social workers who were involved as part of the response to the above incident. These community resources were incredibly important to aid in addressing the unique cultural diversity of the students and families in the community.

Response to the Sudden, Unexpected Death

The crisis response began immediately after Brad's death. Those identified as in immediate need of assistance were the teammates and coaches who were on the field with Brad and those who witnessed the helplessness of the trainers and paramedics. After paramedics had transported Brad to the hospital, the players, coaches, and trainers gathered outside the weight training facility. Following word of Brad's death, the chaplain directed the group in silent prayer. Their grief was displayed in a variety of ways. Many were silent, most were crying. A few displayed extreme anger. The school principal stated that the school would make all necessary arrangements to ensure that they and their classmates would be provided with the necessary supports to meet their needs and that over the next few days the primary goal was to provide for their safety and security.

Feeling safe and secure following a loss are especially important, following a sudden, unexpected loss (Young, 1998). This security is important because the disorientation of a sudden death often evokes exploration of the mystery of life and death, that is, how someone can be living one moment and the next moment is no longer alive. In addition, Oltjenbruns (1996) reminds us, and it bears repeating, that when teens lose a friend they lose companionship, an important confidant, love, and personal support. As a result, the teens' sense of safety and security may be shaken. To address this, the school psychologist conducted a short debriefing and recommended that they all attend one of the group interventions being held the following day in the student support center. Everyone was provided with phone numbers to call while they were away from school in the event they needed immediate assistance.

That afternoon the principal convened the school crisis team and began planning for specific interventions in response to this incident. Because of the sudden and unexpected nature of this death, a call was placed for additional psychologists and adults to be available at school during the next week. The school's media center was designated as the support center and arrangements were made to supply the center with water, soft drinks, snacks, note cards, and pencils. The superintendent was notified, and a phone tree was initiated to notify all teachers of a mandatory meeting prior to the opening of school the next day.

At the staff meeting the next morning, all teachers were provided a fact sheet notifying them of what had transpired and a prepared statement to read to their students. When sharing news of this nature, it is important to provide students with accurate information in a developmentally appropriate manner. In addition, it is important to communicate to students that they are welcome to ask questions and allow them time to express their feelings openly. Because of the sudden nature of the loss and the fact that many of the students were hearing about the death from their classroom teachers,

teachers were encouraged to model listening and sharing thoughts and reactions with students. Students were informed that sharing their personal reactions was not required and that alternative methods of expressing their thoughts, such as writing or drawing, would be made available. Teachers were also advised of the need to consider the diversity of the student population and that cultural and religious differences and the special needs of some students may contribute to a wide array of responses. Finally, teachers and staff were also encouraged to attend the after-school debriefing.

Support for teachers was also provided by distribution of the aforementioned Core Principles for Helping Grieving Children (Perry, 1990, Appendix B). More important was encouraging faculty to suspend normal academic pursuits and to provide an accepting and supportive environment in the classroom in order to facilitate discussion. A Teacher's Guide (Appendix C) provided a sample class discussion format with advice on leading a class discussion, opening the discussion, responding to students, concluding the discussion, and pitfalls to avoid, especially when discussing the topic of death. The roles of teachers and staff are especially important when students receive information of a sudden, unexpected death. Thus, it is especially important that the appropriate materials are provided to facilitate student support.

All school personnel were provided with copies of the information packet, including the Fact Sheet and the Parent Guide on how to help their grieving children, which was being sent home to parents. Finally, a crisis team consisting of the school principal and a school psychologist visited each of Brad's classes throughout the day. In each of these classes, students may experience intense grief reactions as they react to the empty desk. These students may have many questions and experience a range of reactions during the class session. Thus, it is very important to have multiple members of the crisis team available, including a school psychologist or other professional who is prepared to work with bereaved youths.

The student support center was set up to handle those students sent to the center by school personnel and those who came in on their own. Six psychologists, four adult volunteers, and the school nurse were on hand to meet with students in small groups. The psychologists facilitated structured discussions following the NOVA model (Young, 1998) and encouraged students to participate while not demanding participation. Adult volunteers led letter writing and other associated activities that allowed students to make cards, or write letters or notes to express their reactions and feelings to Brad and his family. Although we are not aware of any empirical studies investigating the effectiveness of journaling or making cards as described above, it is a common clinical strategy for having youths share their feelings following a loss. In addition, this process has been associated with tasks of crisis resolution (Slaikeu, 1990) and identified as an important step preceding cognitive mastery of the experience. Furthermore, it is certainly an effective strategy for adults to better understand the thoughts and reactions of youths following a death. In addition, when appropriate, the thoughts and wishes of both peers and adults expressed in selected cards or letters may be shared with the bereaved family.

Special education staff were encouraged to keep their students in class. The added structure, familiarity, and continuity helped to reassure them that school is a safe and secure setting. Because of the sudden, unexpected nature of the death, many students may have increased anxiety or concerns. Changes in the school atmosphere following a death are inevitable, but efforts should be made to avoid disrupting students' sense of security. For many, change and ambiguity contribute to increased stress and may result in additional emotional or behavioral issues. While exceptions were made for higher functioning, mildly handicapped students, the moderate to severe population remained in their classroom. For this special population of students, those expressing concern or displaying grief reactions following the death, the special education teachers followed a modified NOVA protocol for group intervention and facilitated discussions encouraging students to talk about their experiences with loss and grieving.

The training of faculty included alternatives to discussion, such as writing or drawing. These alternative means of expression may be beneficial for those who are reluctant to speak up and for those whose cultural upbringing discourages this kind of activity. For example, art therapy was applied as a response to the tragedy at Columbine High School in Littleton, Colorado. Some of these students expressed their shock, grief, anger, despair, and hope by drawing, painting, and making sculptures. These activities are suggested to facilitate "ventilation" or expression of grief reactions (Young, 1998), which is an important task of crisis resolution (Slaikeu, 1990).

In addition to the above actions at the school to provide support for students and staff, provisions may be made for a town hall meeting to provide information to the community. Because of the circumstances associated with this sudden death, parents were notified that the school would be open in the evening and crisis response professionals would be available. Again, resource lists and general information sheets were also made available to local media who were seeking information. This provided an opportunity to disseminate the information to the community and met the needs of the local media. Clearly, the glamorization of death and communicating that death is a way to obtain a lot of attention is to be avoided. Although the town hall meeting satisfied the needs of peers, parents, and school personnel at River View High School, depending on the circumstances and community, such a meeting may or may not be an appropriate event elsewhere.

While most of this discussion has focused on a response to the diverse needs of high school age adolescents, several individuals who were markedly affected by the incident were adults. It is important not to overlook the needs of school personnel. The meeting with staff prior to the opening of school was incredibly valuable. During that meeting, it was emphasized that caregivers also need to take care of themselves. Using the elements of the triage process, all staff were notified of their responsibility to identify those who might have been influenced most, either by relationship or proximity. Consequently, school personnel identified two coaches and one of the trainers who attempted to revive Brad. Their reactions were significant and warranted more intensive intervention. Furthermore, their needs may have gone unnoticed because of the "machismo" of the football team and because the focus on student needs often overlooks those of adults. Just as the reactions of youths are complicated by the sudden loss, grief reactions of adults are also impacted by the inability to prepare for a loss. Finally, the nature of Brad's death, sudden and unexpected, does not provide immediate answers for why Brad died. As a result, school personnel, namely coaching staff, may experience a type of "survivor guilt," questioning training procedures, physical demands imposed on the athletes, or their lack of preparedness to respond with the necessary first aid. These issues complicate the process of grieving and recovery.

It is important to reinforce the value of developing a community crisis plan. Because of the initial outreach to community-based service providers, the crisis team was able to access a counselor from the local Hospice Family Care group. The counselor provided direct services to the adults in need and also provided additional support services to those students who were identified as most likely in need of ongoing support. Contact with a hospice service in the local school community can be a valuable asset when responding to a sudden and unexpected death. Typically, community hospice services include professionals who are prepared to work with the schools and provide support services for mourning children and families.

During the next few weeks, grief support groups were established for those students who were in need of further support. The design of these support groups included co-facilitators (staff with appropriate training and hospice volunteers), and the emphasis was on a combination of a didactic psychoeducational approach and a process-oriented experiential approach. A number of sources providing appropriate group exercises related to bereavement are available (Gray, 1988; Haasl & Marnocha, 1990; Lehmann, Jimerson, & Gaasch, 2001a, 2001b). Through participation in the support groups, students were able to discuss their ideas with peers, receive and provide feedback and advice, and understand that they did not need to experience the pain and confusion in isolation. They were also provided information regarding grief across time and self-care. For the remainder of the academic year, the school psychologist and other key school personnel were responsible for providing support to students who experienced difficulty associated with the incident. This follow-up support was especially important during the football season over subsequent years as the students and players were reminded of Brad's death.

Preparation

It is difficult to prevent the occurrence of a sudden, unexpected death from natural causes on a school campus. However, a comprehensive crisis plan should be designed to be flexible enough to address the full range of potential crises. The plan should include the following elements as essential to an ongoing effort of preparation:

- Form a school/community crisis response team.
- Prepare a general response plan with specificity and flexibility.

- Maintain an active crisis response committee.
- Train teachers and support staff on group crisis intervention, including important developmental and cultural considerations and provide annual reviews of procedures.
- Encourage professional development for interested school personnel, including understanding grief components and various aspects of a crisis response.
- Provide guidelines for school staff facilitating student coping.
- Develop an accountability system for students during a crisis.
- Coordinate with the community.
- Provide parent education programs.
- Prepare a general follow-up plan in addition to the response plan.

These elements of prevention provide an immeasurable amount of assurance that the response to a crisis will be organized such that: (a) the trauma experienced following a crisis is minimized; (b) the grief experienced by students is supported in a professional manner; (c) the psychological equilibrium of students and faculty members is restored as soon as possible; and (d) parents, teachers, and the school community are aware of the signs and symptoms of posttraumatic stress in students and colleagues and accept the responsibility for referring those individuals for appropriate treatment.

Summary

Professional preparation will provide invaluable resources following a sudden, unexpected death at school. The ongoing training of faculty and staff will help to address the developmental issues of the adolescent by acquiring knowledge of the issues and methods for supportive intervention in both the classroom and a group setting. In addition, training is necessary to identify appropriate procedures for dealing with the special needs students who, during a crisis, may be more vulnerable than other students. A comprehensive school crisis response plan, such as the one developed for River View High School, is essential in preparing to respond to a sudden death at school. The plan must include community resources that can assist in providing appropriate support services for a diverse student population. Utilizing community resources helps to prevent exacerbation of conditions that might arise as a result of developmental or cultural considerations. Given the likelihood that such an event may occur on any given weekday, at any given school, we encourage school psychologists and other school personnel to engage in professional development and prepare a response plan, because it is not a matter of "if," but rather "when," an event will occur. In responding to a sudden, unexpected death at school, our central tenet is that chance favors the prepared professional.

References

Anthony, S. (1972). *The discovery of death in childhood and after* (rev. ed.). New York: Basic Books.

Arnett, J. (1992). Reckless behavior in adolescence: A developmental perspective. *Developmental Review, 12*, 339-373.

Barrett, R. (1995). Contemporary African-American funeral rites and traditions. In L. A. DeSpelder & A. L. Strickland (Eds.), *The path ahead: Reading in death and dying* (pp. 80-92). Mountain View, CA: Mayfield.

Baxter, G. & Stuart, W. (1999). *Death and the adolescent: A resource handbook for bereavement support groups in schools*. Toronto, Canada: University of Toronto Press.

Burak, P. A. (1987). *Crisis management in a cross-cultural setting*. (ERIC Document Service No. ED 329 870). Washington, DC: National Association for Foreign Student Affairs.

de Paula, T., Laganá K., & Gonzalez-Ramirez, L. (1996). Mexican Americans. In J. C. Lipson, S. L. Dibble, & P. A. Minarik (Eds.), *Culture and nursing care: A pocket guide* (pp. 203-221). San Francisco: UCSF Nursing Press.

Doka, K. (1998). Who we are, how we grieve. In K. Doka & J. Davidson (Eds.), *Living with grief: Who we are, how we grieve* (pp. 1-5). Philadelphia: Brunner & Mazel.

Doka, K., & Davidson, J. (Eds.). (1998). *Living with grief: Who we are, how we grieve*. Philadelphia: Brunner & Mazel.

Elkind, D. (1976). *Child development and education: A Piagetian perspective*. New York: Oxford University Press.

Farberow, N.L., & Frederick, C. J. (1978). *Training manual for human services workers in major disasters*. Rockville, MD: National Institute of Mental Health.

Fleming, S., & Balmer, L. (1996). Bereavement in adolescence. In C. Corr & D. Balk (Eds.), *Handbook of adolescent death and bereavement* (pp. 139-154). New York: Springer.

Genovese, F. (1992). Family therapy with adolescents in a school situation. In J. D. Atwood (Ed.), *Family therapy: A systematic behavioral approach* (pp. 298-320). Chicago: Nelson-Hall.

Grabowski, J., & Frantz, T. (1993). Latinos and Anglos: Cultural experiences of grief intensity. *Omega, 26*, 273-285.

Gray, R. (1988). The role of school counselors with bereaved teenagers: With and without peer support groups. *School Counselor, 35*, 185-193.

Grief Resource Foundation. (1990). *Helping children cope with loss*. Dallas, TX: Grief Resource Foundation.

Grollman, E. (Ed.). (1967). *Explaining death to children*. Boston: Beacon Press.

Haasl, B., & Marnocha, J. (1990). *Bereavement support group program for children: Leader manual*. Munci: IN: Accelerated Development.

Harper, D., & Wadsworth, J. (1993). Grief in adults with mental retardation: Preliminary findings. *Research in Developmental Disabilities, 14*, 313-330.

Hassan, R. (1985). Vietnamese families. In D. Storer (Ed.), *Ethnic family values in Australia* (pp. 127-143). Melbourne, Australia: Prentice-Hall.

Hicks, B. (1990). Postvention process. In L. W. Barber (Ed.), *Youth suicide: A comprehensive manual for prevention and intervention* (pp. 79-83). Bloomington, IN: National Educational Service.

Hoffman, M., Levy-Shiff, R., Sohlberg, S., & Zarizki, J. (1992). The impact of stress and coping: Developmental changes in the transition to adolescence. *Journal of Youth & Adolescence, 21*, 451-469

Irish, D., Lundquist, K., & Nelson, V. (1993). *Ethnic variations in dying, death, and grief: Diversity in universality*. Washington, DC: Taylor & Francis.

Kalish, R., & Reynolds, D. (1976). *Death and ethnicity: A psychocultural study*. Los Angeles: The University of Southern California Press.

Klass, D., & Goss, R. (1998). Asian ways of grief. In K. Doka & J. Davidson (Eds.), *Living with grief: Who we are, how we grieve* (p. 13-26). Philadelphia: Brunner & Mazel.

Klass, D., Silverman, P., & Nickman, S. (1996). *Continuing bonds: New understandings of grief*. Washington, DC: Taylor & Francis.

Klicker, R. (2000). *A student dies, a school mourns: Dealing with death and loss in the school community*. Philadelphia: Accelerated Development.

LaFleur, W. R. (1992). *Liquid life: Abortion and Buddhism in Japan*. Princeton, NJ: Princeton University Press.

Lavin, C. (1998). Helping individuals with developmental disabilities. In K. Doka & J. Davidson (Eds.), *Living with grief: Who we are, how we grieve* (pp. 161-180). Philadelphia: Brunner & Mazel.

Lehmann, L., Jimerson, S., & Gaasch, A. (2001a). *Teens together grief support group curriculum: Adolescence edition*. Philadelphia: Brunner & Routledge.

Lehmann, L., Jimerson, S., & Gaasch, A. (2001b). *Grief support group curriculum facilitator's handbook*. Philadelphia: Brunner & Routledge.

Lewis, O. (1969). *A death in the Sanchez family*. New York: Random House.

Locks, S., & Boateng, L. (1996). Black/African Americans. In J. C. Lipson, S. L. Dibble, & P. A. Minarik (Eds.), *Culture and nursing care: A pocket guide* (pp. 37-43). San Francisco: UCSF Nursing Press.

McCann, I., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.

McNeil, J., Silliman, B., & Swihart, J. (1991). Helping adolescents cope with the death of a peer. *Journal of Adolescent Research, 6*, 132-145.

Metzgar, M. (1994). Preparing schools for crisis management. In R. G. Stevenson, (Ed.), *What will we do? Preparing a school community to cope with crises* (pp. 17-35). Amityville, NY: Baywood.

Nara, Y. (1995). May the deceased get enlightenment: An aspect of the enculturation of Buddhism in Japan. *Buddhist-Christian Studies, 15*, 19-42.

O'Brien, J., Goodenow, C., & Espin, O. (1991). Adolescent reactions to the death of a peer. *Adolescence, 26*, 432-440.

Oltjenbruns, K. A. (1991). Positive outcomes of adolescents' experience with grief. *Journal of Adolescent Research, 6*, 43-53.

Oltjenbruns, K. (1996). Death of friend during adolescence: Issues and impacts. In C. Corr & D. Balk (Eds.), *Handbook of adolescent death and bereavement* (pp. 196-216). New York: Springer.

Parkes, C., Laungani, P., & Young, B. (1997). *Death and bereavement across cultures*. New York: Routledge.

Perry, B. D. (1990). *The child's loss: Death, grief and mourning. General guidelines for caretakers of children experiencing death.* (Available from CIVITAS Child Trauma Programs, Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine.)

Phung, T. H. (1979). The family in Vietnam and its social life. In J. K. Whitmore (Ed.), *An introduction to Indochinese history, culture, language, and life* (pp. 77-84). Ann Arbor, MI: University of Michigan.

Podell, C. (1989). Adolescent mourning: The sudden death of a peer. *Clinical Social Work, 17*, 64-78.

Phelps, S., & Jarvis, P. (1994). Coping adolescence: Empirical evidence for a theoretically-based approach to assessing coping. *Journal of Youth and Adolescence, 23*, 359-371.

Reader, I. (1991). *Religion in contemporary Japan*. Honolulu: University of Hawaii Press.

Santrock, J. (1998). *Adolescence* (7th ed.). Boston: McGraw Hill.

Schacter, S. (1991). Adolescent experiences with the death of a peer. *Omega, 24*, 1-11.

Schneidman, E. (1981). Postvention: The care of the bereaved. *Suicide & Life-Threatening Behavior, 11*, 349-359.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Smith, R. (1974). *Ancestor worship in contemporary Japan*. Stanford, CA: Stanford University Press.

U.S. Department of Education. (1999). *Deaths on school campuses*. (Available from National School Safety Center, U.S. Department of Education.)

Vuong, G. T. (1976). *Getting to know Vietnamese and their culture*. New York: Frederick.

Wenckstern, S., & Leenaars, A. (1993). Trauma and suicide in our schools. *Death Studies, 17*, 151-171.

Worden, J. W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (2nd ed.). London: Springer.

Young, M. (1998). *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.

Appendix A

Sample Announcements, Letter, and Classroom Discussion Guidelines

Classroom Announcement

- Something very sad has happened. Chad Sesma, a junior, collapsed and died yesterday during football practice. His death was sudden and unexpected. This kind of sad news is hard to accept. That is all we know at this time.

- Chad is the youngest of four children. He has three older sisters, all of whom are graduates of River View High School.

- Additional information will be provided as soon as the family has had an opportunity to respond to this tragic loss and the information becomes available.

- All students are encouraged to stay with your class and support your classmates who may need additional support. This kind of support network is very beneficial in helping everyone deal with his or her grief and loss. Students who are in need of additional support will be escorted to the Student Support Center where additional services are available.

- The administration discourages the creation of "shrines." Students who may have brought flowers or other things to school and want to contribute to a memorial for Chad are encouraged to take them to the Student Support Center located in the media center. Please consider other more useful and effective ways of expressing your caring and support for Chad and his family. You may want to write Chad and his family a note or letter, or provide a contribution to a charity of the family's choice. You will be notified of the family's wishes as soon as that information becomes available.

- The media have little respect for the privacy of Chad and his family. If you are approached by a member of the media (a reporter or anyone who is not identified as a representative of the school), please refer them to the principal's office.

Sample Announcement to Faculty

Important Faculty Notice

1. On Monday afternoon, November 15, Chad Sesma, a junior, died suddenly and unexpectedly following preliminary warm-up activities during football practice.

2. A crisis plan has been developed and is in place.

    - A faculty/parent support and information center has been arranged and is located in room 104.
    - A student support center has been established and is located in the media center.
    - A media center has been set up in the staff lounge in the administration building where the requests of the media can be more appropriately addressed.
    - A staff debriefing will be conducted at the end of today's class schedule, at 2:30 in room 301.
    - A letter from the principal notifying parents of the tragedy and providing guidelines for helping grieving students is being sent home.

3. Faculty are encouraged to have students remain with their peers in the classroom, if at all possible. The networking and culture of the classroom can be very beneficial.

4. Please deal with your students at your level of comfort.

5. Staff will be supported in their efforts to give comfort to students. Materials and sample scripts are available. Additional help is available to anyone who needs it. If you feel that you cannot conduct your class and are not able to provide comfort to your students, please notify the office and a substitute will be made available.

6. Additional information will be provided as soon as it is made available. Please check with the faculty support center in room 104 for updates.

Appendix A continued on p. 472

Appendix A continued

Sample Letter To Send Home (school letterhead)

Dear Parent(s)/Guardian:

We have suffered a tragedy at our school. On Monday, November 15, 2000, one of our students, Chad Sesma, died suddenly and unexpectedly. In addition to our grief over the loss of this member of our school community, we are sensitive to the fact that such an event has an impact on other students.

Students will have varied responses to the death of a peer. A wide range of reactions is normal in the grief process. In response to this tragedy, the school has implemented a plan, which allows students an opportunity to talk about their thoughts, reactions, and feelings with trained professional staff. We expect that some will seek out this help, while others may not. We encourage you to discuss with your student their reactions regarding Chad's death. Enclosed is some information that could be helpful as you respond to your child's concerns. If you determine that your child needs further professional counseling, please feel free to contact the school. Resources for services within the community will be made available to assist you.

Please do not hesitate to contact the school regarding your requests or concerns at 962-3301, ext. 222.

Sincerely,

Susan Schmidt, Principal

Responding to Critical Incidents: Suggested Class Discussion Format

School is a place where learning takes place, where it is safe to ask questions and obtain factual information. Students have the capacity to cope with stronger feelings of loss than many of us realize. If they sense that parents and/or teachers are hiding something, their suspicions can lead to fears and fantasies that may be more problematic for them than the truth. A teacher's expression of sorrow in class conveys to students that strong emotions are natural and that mourning does not have to be hidden. When students are allowed to grieve in a supervised setting, they can have the comfort and reassurance they need. When people are able to share their reactions, experiences, and feelings when confronted with tragedy, they feel less helpless and alone.

Advice for Teachers

The following general principles can be helpful when working with students:

- It is important to acknowledge the reality of the critical incident and your willingness to talk about it.
- Be simple and straightforward. Discuss death or other tragedy in terms the student can easily understand.
- Give the facts regarding the incident in a concrete, clear, and accurate manner. If the information to communicate is contained in a written record, it can only be shared within the limits of the Freedom Of Information Act. There is no one rule to describe when such information can be shared. Each situation will need to be discussed by the school crisis team.
- Express your own feelings in an open, calm way that encourages students to express their grief or fear. Some students choose not to talk; the discussion of the event strikes them as a source of more pain or fear, and some have a hard time verbalizing their feelings. These students should not be pressured to talk.
- Be sensitive to possible cultural differences in methods of grieving.
- Project confidence and calmness. Be encouraging and reassuring.
- Listen, acknowledge the loss or fear, and have a nonjudgmental attitude.
- Be patient. Many times because of their need for reassurance, students will repeat the same questions. Some students may tell about their relationship and reconstruct the loss. Repetitions of this sort are part of the normal grieving process.
- Be prepared for any student(s) who may feel the need to discuss unpleasant features of the relationship. Anger directed toward the deceased person is one of many normal responses to loss.
- Students who may have had recent conflict with the deceased may be particularly affected.
- Assess the meaning of the loss for each student. Pay close attention to those who have experienced other recent deaths or losses or to those who have emotional problems.

Appendix A continued on p. 474

Appendix A continued

- Expect regressive behaviors such as fear of being left alone, especially with younger grade students. Expect physical complaints such as stomachaches and headaches.

- Be aware that high school age students may show their empathy during grieving through physical contact such as hugging or touching on the arm.

- Avoid imposing your own theology and/or personal beliefs.

- Assess which students are in need of additional support and refer them to the designated counseling center for individual assessment. Have someone accompany them there.

Class Discussion

There is no right or wrong way to talk about death or other tragedy. The following are only examples to guide your class discussion of the incident. This sample can be changed to fit the situation or the students' needs. Classroom discussion will vary in length depending upon whether the incident occurred at school where students may have witnessed some aspect of the event, the age of the students, and their emotional involvement with the injured or deceased. Some discussion may be as brief as a few minutes, while others will continue for an entire class period.

Beginning Script

1. "Something very sad has happened. Chad Sesma, a junior, has died suddenly and unexpectedly. This kind of sad news is hard to accept. You will probably have many reactions and feelings in the next few minutes. You could be sad, angry, confused, depressed, afraid, or have no feelings at all for some time. When I've felt this way it has helped to talk to someone. Sharing my thoughts made it easier, even though it was no less painful to deal with the tragedy. If you'd like to talk about the situation, I'd be glad to take time to do that. I'll try to answer any questions as well as I can."

2. Encourage each student to share his or her own memories of the incident. "What are some of the things you want to remember about Chad?"

Responses

3. Acknowledge that a wide variety of feelings is normal. There is no one right way to react to a tragedy. Feelings will vary from student to student and will change over time. Some possible responses include:

- "Some of you feel angry that Chad died. What can you do with your angry feelings?"

- "It's okay that some of you are very scared or angry as a result of hearing about this tragedy, and some of you may be only a little angry or afraid."

- "Because of Chad's death you may be reminded of others whom you cared for who have died."

- "It's okay to forget Chad sometimes when you work or play."

- "It's okay to cry—it's really alright."

4. Acknowledge that you don't have all the answers. Often there is more comfort from an honest "I don't know," than from an attempt at explanations that don't sound credible.

5. Acknowledge the various cultural or religious beliefs that may be expressed.

Conclusion

6. Focus on the strengths and supports the students have to get the help they need:

   - the support that comes from sharing feelings of grief or fear with others,

   - the student's support network, such as family, significant adults, teachers, counselors, and friends. Have each student think of someone he/she can go to for support, and

   - the student's individual strengths that provide self-support.

7. Talk about the natural healing process. "Over time the pain of missing Chad won't hurt so much. That's the way it should be. It doesn't mean that you loved Chad any less."

8. "Class is almost over, and it seems there's more to talk about. Perhaps we can set aside some time tomorrow."

9. Give information about the designated counseling center and the school psychologist's office. "The counseling center will be in the nurse's office for the next three days. You can use the center whenever you feel the need. The people working in the center are there to help you."

Appendix A continued on p. 476

Appendix A continued

10. It is helpful to channel the feelings of the class into appropriate expressions of concern. It may be comforting to students to feel they have participated in some activity to express their feelings and to reach out to grieving families affected by the crisis.

Statements to Avoid

11. Avoid euphemisms for death such as "passed away," "gone," or "sleep," which may lead to confusion for some.

12. Avoid the general statement, "If you need anything, tell me ...." It is better to say: "Would it help if I ... ?" Students may find it difficult to verbalize their own needs and will require assistance to find a way to describe the support they want.

13. Avoid saying "I know just how you feel." It is more empathic to say: "You must be having a lot of feelings right now."

14. Avoid blaming or judging.

Appendix B

Core Principles for Helping Grieving Children

The Child's Loss:
Death, Grief, and Mourning:
General Guidelines for Caretakers of Children Experiencing Death
CIVITAS Child Trauma Programs
Department of Psychiatry and Behavioral Sciences
Baylor College of Medicine, Bruce D. Perry, M.D., Ph.D.

This Guide articulates some issues related to understanding a child's complex set of reactions to loss as a result of a traumatic death. While focused on traumatic death, this information may be helpful to families, caseworkers, teachers and other adults working and living with any grieving children. This simple guide is intended to inform and provide general principles—it is not intended be comprehensive or to exclude other observations or approaches to helping grieving children.

1. ***Do not be afraid to talk about the traumatic event.*** Children do not benefit from "not thinking about it" or "putting it out of their minds." If a child senses that his/her caretakers are upset about the event, they will not bring it up. In the long run, this only makes the child's recovery more difficult. Don't bring it up on your own, but when the child brings it up, don't avoid discussion, listen to the child, answer questions, provide comfort and support. We often have no good verbal explanations, but listening and not avoiding or overreacting to the subject and then comforting the child will have a critical and long-lasting positive effect.

2. ***Be honest, open and clear.*** Give children the facts regarding the death. While there is no need to describe great lingering detail, the important details should be given. These often are horrifying but it is important to give factual information to the child—the imagination of a child will "fill in" the details if they are not given. Too often these imagined details are distorted, inaccurate and more horrifying than the actual details and can interfere with the long term healing process.

3. ***Be prepared to discuss the same details again and again.*** Expect to hear things from the child, which indicate that they didn't "hear" you when you told them the first time. The powerful, pervasive implications of death for the child can be overwhelming—a traumatic event. The child's responses to death of a parent, sibling or other loved one will be similar to the child's responses to other traumatic events. This will include emotional numbing, avoidance, sadness, regression, episodic manifestations of anger, frustration, fear of the unknown (future), helplessness and confusion.

- The child will have recurring, intrusive and emotionally evocative recollections of the loved one and about the death of the loved one.

Appendix B continued on p. 478

Appendix B continued

- If there is no clear image of the death, the child will "imagine" various scenarios. These images will return and return. As they do, the child (if he or she feels safe and supported by the adults around them) will ask about death, the specifics of the death and the loved one. Patiently, repeat clear, honest facts for the child. If you don't know something—if you also have wondered about the nature of death or a detail in this specific loss—tell the child. Help the child explore possible explanations, let the child understand that you and others can and, often, must live with many unknowns. In this process, let the child know, however, that there are things we do know—things we do understand. Bring positive memories, images and recollections of the loved one into the conversation.

4. ***Use age-appropriate language and explanations.*** The timing and language used in this process is important. In the immediate time period following the death, the child will be much less "available" to receive and process information. As the child gets further away from the event, they will be able to process more, digest more, and understand more. During this long process, the child continues to have opportunities for re-experiencing—for hearing the same material again and again. The child will experience and process the very same material differently at different times following the death. In the long run, the opportunity to reprocess will facilitate the development of a mature understanding of the loss.

- Children at different ages have very different concepts of death.
- Very young children may have little appreciation of the permanent quality of death. Try not to associate sleep and death. When these two become associated, it is not surprising that children become afraid of sleep. They become afraid of loved one's going to sleep. Try to get some understanding from the child of what they think death is—do they have a view of afterlife, are there specific fears about death and so forth. The more you understand about the child's concept of death, the easier it will be for you to communicate with the child in a meaningful fashion.

5. ***Help the children avoid false reasoning about the cause of the death.*** Young children often make false assumptions about the causes of major events. Unfortunately these assumptions may include some sense that they were at fault for the event—including the death of a loved one. Adults often assume that causality is clear—dying in a car accident, being shot in a drive-by shooting, dying in a fire. The child may very easily think that—mom died in the car accident because she was coming to get me or because the other driver was mad at her—the person that shot my brother was shooting at me and hit my brother because he was in my room—the fire was God's way of punishing (or martyring) my family. Be clear. Explore the child's evolving sense of causality. Correct and clarify as you see false reasoning develop. Over time, the ability of the child to cope is related to the ability of the child to understand, and while

some elements of death and tragedy seem beyond understanding, this can be explained to a child—some things we don't know. Don't let the child develop a sense that there is a secret about the event—this can be very destructive. Let the child know that adults cannot and will not understand some things either.

6. ***Surviving children often feel guilty.*** A child surviving when family members die may often feel guilty. This can be a very destructive and pervasive belief. The amount of guilt a child feels may often be related to the degree to which they develop and maintain false assumptions about the event (see No. 4).

- An important principle in this process is that children do not know how to verbalize or express guilt in the same fashion as adults. Guilt, as expressed in children, may often be best observed in behaviors and emotions, which are related to self-hatred and self-destruction. The child will likely not be able to articulate that survivor guilt is intimately related to their sense of worthlessness, self-abusive or destructive behaviors.

- The children surviving a parent's sudden death will have great survivor guilt. Was there something wrong or bad about me? I could have been there—I should have been there. These thoughts will recur in any variety of permutations. And most of the time the outcome of these thoughts will be guilt. If these children's caretakers, therapists and teachers can minimize these potentially escalating and destructive ideas the child's recovery will be eased.

7. ***Distinguish between grief and mourning.*** Grief is the label for the set of emotional, cognitive, behavioral and physical reactions that are seen following the death of a loved one. There are sets of normal responses, which include denial, emotional numbing, anger, rage, rushes of anxiety (pangs), sadness, fear, confusion, difficulty sleeping, regression in children, "stomach" upset, loss of appetite, hysterical materializations (transient visual or auditory misperceptions that you have seen or heard the dead loved one) and many other potential symptoms. These symptoms are similar to those often seen in the acute post-traumatic period.

- Mourning is the formalized process of responding to the death. This includes memorial services, funerals, wakes, mourning dress and so forth. These semi-ritualized approaches are very useful in organizing and focusing the grief reaction in the immediate post-death period. It is important to allow children to participate in elements of this process. A major healing element of mourning is that it is one way in which someone can "have control over" the way in which they experience a trauma. Rather than sitting alone with recurring intrusive thoughts about the death, one can, in a controlled fashion recall the lost one without focusing on the death event. The degree of control in coping with a traumatic event is very important in determining how destructive the event becomes over time.

Appendix B continued on p. 480

Appendix B continued

8. Grief is normal, persisting grief reactions are not. In the same way that a persisting presence of the acute reaction to trauma can signify major problems so can a persisting grief reaction. If symptoms listed above persist beyond six months or if the symptoms interfere with any aspect of functioning, they need to be addressed. If the child is in therapy, communicate this with the therapist. Find out if functioning in school is altered, watch for changes in patterns of play, loss of interest in activities—be observant, be patient, be tolerant, be sympathetic. These children have been hurt and are in continuing pain.

9. Do not avoid the topic when the child brings it up. Similar to the principles of dealing with other trauma, the adults around the child need to be available when the children want to talk but avoid probing when the children don't want to talk. This may mean answering one question—it may mean struggling with a very difficult question "Does it hurt when you burn to death?" Don't be surprised if in the middle of your struggle for the "right" answer the child returns to play and acts disinterested. They have been unable to tolerate the level of emotional intensity and have avoided it in some adaptive fashion.

- Children will sense if the topic is emotionally difficult for adults around them.
- The child will try to please the adults—either avoiding emotional topics or persisting with topics that they sense the adults find more pleasant. Try to gauge your own sense of discomfort and directly address this with the child. It is reassuring to the child that they are not alone in some of their emotional upset. Stay in control—this is reassuring but verbal acknowledgment of sadness, hurt and anger by the adult can be important.

10. Be available, nurturing, reassuring and predictable. Do your best to be available, loving, supportive and predictable. All of these things make the child's work easier. They feel safer and cared for. The loss of parents, siblings and other loved ones is extremely traumatic and will forever change these children's lives. The child has, in some sense, a life long task of working, reworking—experiencing and reexperiencing the loss of these loved ones. Each holiday—each "family" occasion—will bring the loss, the death and the ghost of the loved one to this child. Available, nurturing and caring caretakers, teachers, therapists and caseworkers will all make this journey easier.

11. Inform adults and children in the child's world what has happened. Let teachers, counselors, parents of the child's friends and, if appropriate, the child's peers know some of the pain that this child is living with. Sometimes this can allow the people in the child's life to give them the small amount of tolerance or understanding or nurturing that will smooth the way. People can often be intolerant or callous when dealing with the pain of a grieving child: " Isn't it about time they got over this?" When you see that this is occurring don't be shy about taking this person aside and educating them.

12. Expect unusual "sensory" experiences. Over the six months following the loss, children (and adults) will often experience unusual visual, auditory or tactile sensations. A child may think they hear the person's voice—or they think they saw them in a crowd—or out of the corner of their eye they may see their reflection in a window. At bedtime or when awaking, these misperceptions are more common. They may be disturbing to parents, caretakers and the child. Reassure the child. These "visions" are often interpreted in context of a religious belief system—"they came back to tell me it was ok—they are still with me." This can be important for the child and there is no reason to undermine these feelings. These "hysterical materializations" are common and often mislabeled as visual or auditory "hallucinations." If you have questions about these symptoms contact an experienced mental health professional or physician.

13. Take advantage of other resources. There are many other well-trained professionals willing to help you and the child in your care with these problems. Take advantage of them. If the child is in therapy, talk to the therapist. Call our office: we are always interested in helping the children. Always remember that this does not go away—the way the child experiences it changes, evolves and matures. The loss of a parent, a sibling, a peer will always be with these children. Help them, over time with love and understanding, evolve a mature sense of this loss.

Note

From *The Child's Loss: Death, Grief and Mourning: General Guidelines for Caretakers of Children Experiencing Death*, by Bruce D. Perry, M.D., Ph.D.; Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine. Reprinted with permission.

Appendix C

When Does the Hurting Stop? A Parent Guide for Assisting Teens Through Trauma and Loss

Assisting Teenagers Through Loss

The loss of people we care for is very painful and confusing. We recognize pain expressed by tears, but pain evidenced by withdrawal, hopelessness and anger can be harder to detect. Sometime we see pain and grief as short term so when certain behaviors appear, we wonder what is behind them.

Adolescents, as noted, often present an image of strength. Unfortunately, this results in a tendency for emotions to be buried, only to be resurrected later, sometimes in less healthy ways.

The need not to reveal weakness often causes much pain and grief to go unnoticed. These coping strategies can often be rewarded unwittingly with comments such as, "You are handling things very well." While this may appear to be the case, it is often an illusion.

How Can You Help?

While most helping response occurs in the first few weeks after a traumatic event, grief usually lasts longer than anticipated. The effects of grief are often revisited long after the event. These delayed, seemingly unrelated responses to grief can be baffling. It is important to keep this in mind when dealing with behavior that is uncharacteristic.

- Be a listener. Most help comes from genuine concern that listens rather than seeks to give the "right" piece of advice. Communicate that grieving can last longer than anyone expects although the intensity usually subsides. Certain events such as birthdays and holidays may result in a "revisitation" of grief.

- Do not avoid talking about the person or event because you feel it might reawaken the pain. Avoidance of the topic conveys a lack of caring rather than the more likely fact that you do not know what to say. Usually your teenager will want to talk, although it may not come in the fashion or the time you had planned. Follow their lead and be a listener.

- Try not to make any unnecessary changes during this time. Times of grief and loss are not the times to be making important decisions. Attempt to keep the situation as normalized as possible.

Perhaps the greatest challenge you, as a parent has, is to encourage and allow the admittance and healthy expression of grief.

What to Watch For

Trouble signs to watch for in adolescents following loss may include:

- withdrawal and isolation
- physical complaints (headache, stomach pain)
- emotional concerns (depression, sadness, tension, suicidal thoughts, confusion)
- anti-social behavior (stealing, acting out, aggression, substance abuse)
- school problems (avoidance, disruptive behavior, academic failure)

Most of these are temporary. Teenagers who appear to be withdrawn and who isolate themselves from family and friends may be experiencing emotional difficulties. The need to appear competent may work against their reaching out to others for assistance. Most grief reactions are normal responses to disaster or loss; however, it is imperative that suicidal thinking be treated seriously and that help is sought.

Loss and disaster can thrust teenagers into an adult role. Regardless of whether these results occur, it is important they give themselves permission to grieve.

Understanding the Grief Process

While the following stages commonly occur in the grief experience, it is important to remember that grief does not follow a defined pattern. These stages may be experienced repeatedly, in differing sequence and with differing intensity.

Denial is a shock absorber, which temporarily reduces the full impact of the crisis, such as a person's unwillingness to talk about the loss. In the early stages denial isn't something that is wrong; however, problems can occur if it continues. Give permission to feel the feeling.

Anger/guilt often occur due to a person's feeling of powerlessness over the loss. Questions include: How could he/she do this to me? Why would God allow it? How could this happen to someone at our school? Blaming others can also be a common response. It is important to admit the anger, identify the real source of the anger, and understand that it is okay to be angry. Seek healthy ways to express it such as through strenuous physical activity, keeping a journal, sketching or talking with people you trust.

Appendix C continued on p. 484

Appendix C continued

Sorrow/depression is evidenced by some or all of the following: crying, isolation, silence, a loss of energy, and an inability to sleep. Allow and encourage expression of grief. Emphasize that crying is not a sign of weakness; rather it is the facing and acknowledgment of loss. Recording thoughts in a journal can also be very healing. Activity is helpful for depression, although sometimes depression is so deep that even activity seems too difficult. Referral to the family physician is encouraged for depression that persists.

Bargaining is a means of trying to regain control or to make sense of what has occurred. This often takes the form of a promise to God that things will change if only he does something. The question "Why?" is very naturally asked through all stages but is perhaps most prevalent in the anger and the bargaining phase. The real problem cannot be faced until the "why" is abandoned and the person looks as "who, when, where and how" things happened. The reality of what has happened cannot be changed.

Acceptance and admission of our powerlessness in the situation is not quickly or easily reached. Having grieved we can move on with life. Emphasize that acceptance is not a matter of forgetting the person or minimizing the pain. In fact, it is a full acceptance that the loss was real, significant and painful.

A Difficult Time

The events of recent days have, no doubt, been upsetting for you and your child. Traumatic events shake the world that we had considered safe and predictable. These events also create high levels of confusion and apprehension. Discussion in the news and at the school often adds to the disruption.

The experience of a loss or a sudden violent event can produce intense anxiety and fear. These feelings are very normal. Suffering, loss and death have shattered the teenagers' sense of invincibility and immortality. Teenagers often present an image of strength and other forms of "best foot forward." Unfortunately, this results in a tendency for emotions to be buried, only to be resurrected later, sometimes in less healthy ways.

The need not to reveal weakness often causes much pain and grief to go unnoticed. These coping strategies can often be rewarded unwittingly with comments such as, "You are handling things very well." While this may appear to be the case, it is often an illusion.

This guide is intended to help you, as a parent, to understand and help your child through this difficult time.

Other Sources of Help

Loss and disaster wound many, even those who seem not to be touched by what occurred. There is no shame in expressing your pain as well as the pain felt by your children. Parents are encouraged to seek help from people in the community. School counselors, school psychologists, counseling clinics, Mental Health Department personnel, clergy, etc., are just some of the resources available to assist you and your family.

Caring for the Caregiver

Disaster and loss can have a profound effect far beyond anything this guide can address. Those in the midst of crisis understand that it is one thing to know helpful ideas; it is quite another issue to practice them. At these times, even the simplest steps can seem almost impossible. Calming the distressed child or feeling confined by the depressed child can be emotionally draining in the extreme.

Walt Whitman said, "I do not ask the wounded person how he feels, I myself become the wounded person." At one level Whitman is describing the attitude needed to help people in pain but his words also point out that the wounds felt by those we love, are felt by us as well. In order to take care of yourself, be certain not to put unreasonable demands on yourself by trying to be all things to all people. Expectation and normal daily activities may need to be scaled down. Remember:

- Grief usually lasts longer than anticipated. Most response occurs in the first days and weeks but the effects of grief are often revisited for some time.
- Most of your child's reactions are normal responses to disaster or loss.

Note
From Responding to Critical Incidents: A Resource Guide for Schools. British Columbia Ministry of Education, September 1998. Reprinted with permission.

24

School Violence

危
機

Michael B. Brown, Ph.D.
East Carolina University

It was a clear, crisp day as busloads of elementary school students arrived at school. At the parent drop-off site a blue station wagon had just stopped to let off a fourth-grade student. As the car began to pull away, a man ran up to the female driver and fired three shots into the car. Students, faculty, and parents ran screaming for cover as the station wagon crashed into another car. While some inside the building heard the shots and ran, others went on about their business as usual, unaware of the tragedy that had just occurred in the front parking lot. Children who witnessed the event were very frightened, as were others who heard about what happened. Word quickly traveled through the media that a parent had been shot and killed at school by her estranged spouse. Even though no children were involved in the shooting, distraught parents began calling and arriving at the school to ascertain their children's safety. Building faculty and mental health staff started to implement the site crisis intervention plan while they awaited the arrival of the district crisis intervention team.

The occurrence of violence on school grounds creates a significant and lasting reaction in students, parents, school personnel, and members of the community. School mental health professionals need to know how to respond effectively to the crisis of school violence and plan ahead. This chapter provides basic information about school violence, issues that arise from violent behavior in schools, and how school clinicians can respond to minimize negative outcomes.

Violence in schools—including weapons, fighting, threats, robberies, and victimization—seems to be occurring frequently in the United States (Hennes, 1998) and Canada (Carter & Stewin, 2000). Kingery, Coggeshall, and Alford (1998) provide an especially useful synopsis of four national school violence surveys that they believe are the most valuable: The Youth Risk Behavior Survey (Centers for Disease Control and Prevention, 1997), the Monitoring the Future Survey (Bachman, Johnston, & O'Malley, 1997), the National Longitudinal Study of Adolescent Health (Carolina Population Center, 1997), and the National Crime Victimization Survey: School

Crime Supplement (U.S. Department of Justice, 1997). Although each of these studies uses a nationally representative anonymous survey, the surveys differ in the time frame respondents are asked to address, ranging from one to six months prior to taking the survey. Responses to these surveys indicate that weapon-involved threats and injuries were reported among 9 to 12% of boys and 4.5 to 7% of girls between grades 9 and 12. Some 37.5 to 46.3% of high school males and 21.5 to 31.6% of females experienced theft and property damage. Physical fighting on school property occurred in 5.5 to 29.4% of males and 5.6 to 12% of females in grades 7 through 12.

Although most school professionals focus on students' experience of violence in the school setting, it is also important to consider that violence occurs in other areas of student life. Violence and crime in many communities is on the increase (Marans, 1994). Neighborhood crime and violence have an effect on children both in and out of school, and children in urban areas are reported to be especially likely to feel unsafe in their communities (Bowen & Bowen, 1999). For example, 5% of suburban children and more than 50% of urban children reported that they had witnessed a shooting (Singer, Anglin, Song, & Lunghofer, 1995). Exposure to domestic violence or victimization through physical or sexual abuse also occurs with alarming frequency (Trickett & Schellenbach, 1998). Some children are victimized on multiple fronts; well over half of children who witness domestic violence also personally experience physical or sexual abuse (McKibben, DeVos, & Newberger, 1989). This situation is also complicated by the fact that children are likely to be both victims and perpetrators of violent acts (Chandras, 1999).

Although children's exposure to violence in or out of the school is worrisome, the majority of students in the national studies cited above indicated that they felt safe at school. Moreover, school violence has decreased for the past three years (U.S. Department of Education & U.S. Department of Justice, 2000) and fewer than 1% of juvenile deaths occur at school (U.S. Department of Education & U.S. Department of Justice, 1999). Schools often are viewed as "refuges" for children from disrupted families or communities and can play a significant role as a protective factor in children's lives (Garbarino, Dubrow, Kostelny, & Pardo, 1992). School personnel must be prepared to respond to violence in the schools, but they are advised to obtain local data about the occurrence of violence and to communicate regularly and accurately with students and parents about school safety (Trump, 2000).

Unique Crisis Issues

Communities affected by recent school shootings have experienced severe pain and loss because of school violence (Furlong, Kingery, & Bates, 2001). Murder, in particular, affects the entire school community and those involved with the school community (Klicker, 2000). Parents, elected officials, and other members of the community often focus intently on issues of school safety following a violent incident in school. Exposure to violence has serious effects on children, including disruption of development, substance use, somatic complaints, and psychiatric disorders such as posttraumatic stress disorder (PTSD) (Jenkins & Bell, 1997). PTSD resulting from an event caused by other persons (such as most incidents of school violence) is likely to be more serious and persistent than that resulting from nonhuman design, such as a natural disaster (American Psychiatric Association, 2000). It is therefore important to provide interventions for children, their families, and other affected members of the community.

School violence can cause children to be concerned about their safety both inside and outside of school. Parents and teachers may also be concerned about children's safety at school. School personnel must act quickly to ensure the physical safety of students and staff. Psychological well-being must be a concern of the crisis intervention team, and activities should be directed to promote routine and structure to the extent possible. This effort, along with providing crisis intervention activities, will assist the school community to restore its sense of safety and security.

Incidents of school violence also attract a great deal of media attention, with media coverage lasting from one day to more than a week (Poland & McCormick, 2000). In addition to the coverage provided during and shortly after an incident, the media may choose to provide coverage at various anniversary dates, potentially complicating the school's recovery process. While the media have a legitimate function to perform, several commentators have cautioned that media coverage of school violence has contributed to the myth that school violence has increased during the past few years (Hyman et al., 1997; McLean, 1996). Media personnel may lack specific knowledge about schools and about school violence in particular, and media coverage may sensationalize the event (Trump, 2000). School personnel should be prepared to work with members of the media, provide accurate information, and develop a positive relationship with the media before and after a violent incident (Poland & McCormick, 2000).

Cultural, Demographic, and Developmental Issues

Experiences with violence. Although violence can affect children from all racial, ethnic, and socioeconomic backgrounds, evidence indicates that their experience with violence may differ based on demographic variables. Bowen and Bowen (1999) found that males are more likely to have personal experiences with danger in the community and school. Girls are more likely to be victims of sexual assault, while boys report greater personal experience with other types of violence, such as assaults and shootings (Jenkins & Bell, 1994). Boys are also more likely to have witnessed violence in the community, while girls are more likely to have been exposed to violence in the home (Singer et al., 1995).

White children have the lowest average report of violence exposure, while African-American children have the highest or next highest exposure on measures of danger, with the exception of personal threats at school, where they have the lowest level (Bowen & Bowen, 1999). African-American adolescents are especially likely to experience criminal acts and be victims of homicide (Ozer, Brindis, Millstein, Knopf, & Irwin, 1997).

While it makes sense that older children would be more exposed to violence, especially in the community, studies have demonstrated that even very young children frequently witness violent acts (Taylor, Zuckerman, Harik, & Groves, 1994). Middle school students report the greatest number of personal threats at school, with high school students reporting higher scores on measures of danger in the neighborhood and school crime and violence (Bowen & Bowen, 1999).

The type and amount of violent acts witnessed by children varies considerably depending on where children reside (Singer et al., 1995). Urban students have higher mean scores for negative neighborhood peer behavior and threats and school crime and violence (Bowen & Bowen, 1999). Notably, urban children do not seem to differ on the average number of personal threats at school. Children living in urban inner-city areas are especially likely to be exposed to crime and violence (Jenkins & Bell, 1994). Although many think that poor inner-city children are at most risk, the majority of high visibility school shootings that occurred in the late 1990s were perpetrated by boys from middle and working class families—evidence that school violence is an issue that is not limited by socioeconomic variables.

Cultural issues in crisis response. Culture affects the ways that people perceive and interpret traumatic events (Sieckert, 1998). The routines and traditions of a cultural group may help the survivors of a tragedy express their grief in a manageable fashion. School personnel should make an effort to understand the perspectives and traditions of the cultural groups to which their staff and students belong. The optimal time to do this is before a crisis occurs, and it is best done by establishing a dialogue between the school and different cultural and ethnic groups. Not only does this process provide useful information, but it also establishes a level of trust among persons of different cultures.

Sieckert (1998) summarizes a variety of helpful suggestions for crisis intervention with a cultural focus. It must be remembered that an important crisis intervention goal is to build trust between the intervenor and the person in crisis. Attainment of this goal is facilitated by paying attention to customs and symbols and being aware of personal cultural biases and differences. It is important that intervenors understand the meaning of life, death, and suffering from the perspective of other cultures. Crisis responders who assist students from different cultures should acknowledge their limitations with language or customs and ask individuals in crisis to let them know if something has been misunderstood or interpreted inappropriately. Intervenors should explain their role and how they usually do their job. It is often useful to ask the person from a different culture to describe what crisis responders could do that would be most helpful to them. Finally, it is important to understand the practical problems with which everyone must deal with regardless of culture.

Reactions to violence. Children will have negative reactions because of being victimized at home, school, or in the community. Reactions can be transient or may be more enduring, as in the case of PTSD. Even the threat of violence or perception of danger has resulted in some children developing symptoms of PTSD (Pynoos et al., 1987). In addition to the direct effects of violence or the perception of danger, there may also be a reduction in the quality or availability of learning opportunities at school or in the community (Bowen & Bowen, 1999). The degree of traumatization depends on a variety of factors (Marans, 1994), including children's proximity to the event, relationship to the victims or perpetrator, and response of their family to the event. Children's reactions to violence also depend on whether the event represents a single trauma in their lives or is part of a pattern of chronic loss and trauma. Additionally, children's developmental level and degree of support from the family, school, and community influence the outcome. (For additional information on identifying psychological trauma victims, refer to Chapter 19 in this volume.)

After psychological trauma, children are likely to experience disbelief or denial of the event, concern about the safety of significant others, and a fascination with the traumatic event or desire to attribute blame for the event (Marans, 1994). Jenkins and Bell (1997) provide a useful summary of the reactions of children of different ages after exposure to violence. Preschool children are likely to display regressive symptoms such as separation anxiety, bed-wetting, and withdrawal following trauma. They may also reenact the event during play. Nightmares, separation anxiety, and sleep disturbances are common. School-age children may have inconsistent behavior and have difficulty attending and concentrating. Some will respond with an increase in activity or aggressive behavior, while others might respond with greater inhibition of behavior. Somatic complaints such as headaches and stomachaches are common. Adolescents who are exposed to violence may become more aggressive and engage in self-destructive behaviors (such as substance abuse or promiscuity). Some adolescents may be at risk for premature identity formation because of the traumatic event.

Exposure to violence also affects a variety of school-related factors (Bowen & Bowen, 1999). As exposure to violence and personal threats in the neighborhood and the school increases, attendance goes down. As neighborhood and school dangers rise, school behavior problems increase and school grades decrease.

Children who have been exposed to violence may also develop PTSD. The symptoms of PTSD (Brown, 1996; Garbarino & Kostelny, 1997) include intrusive thoughts and images, hypervigilance and exaggerated startle response, and emotional numbing. Regression of behavior, reenactment of the violent act, and sleep disturbances may also be present. Some children may become fearful, have nightmares, and experience amnesia.

Crisis Intervention

Crisis events can be thought of as individual student crises and school crises (Cornell & Sheras, 1998). Individual student crises affect one or a few students and typically do not have an impact on the entire school (although prompt intervention in an individual crisis may prevent it from having schoolwide effects). School crises affect more persons and require a more complex response from school personnel. While school personnel typically have the most experience in dealing with individual student crises, additional planning and preparation is necessary to optimally deal with school-wide crises. The following interventions are aimed at dealing with a violent event that affects more than an individual student and should provide guidance for professionals involved in helping schools after violence has occurred. Schools are especially well-suited to provide what Klingman (1993) calls the generic approach to crisis intervention. This approach recognizes that certain patterns of behavior can be expected during a crisis, and large-scale intervention can focus on meeting the expected needs of the majority of the school community. Individual intervention can be provided for those members of the school community who require more support than that provided by the large-scale approach.

Intervention after violence must take into account the anticipated reactions of students, parents, and staff. The task is not to act as if every child who is exposed to trauma will be overwhelmed by the experience, but to reestablish a sense of safety and security for all, identify the needs of individual children, and provide services to reduce the potential morbidity (Jenkins & Bell, 1997). Response after school crisis can best be thought of as occurring in two stages: the immediate response to crisis and the longer-term response or "post-crisis crisis" (Trump, 2000, p. 123).

Developing evidence shows that intervention after trauma is successful in preventing or reducing later problems. For example, Amidon (1996) found that treatment lessened the symptoms of PTSD for children who experienced abuse. DeLuca, Hazen, and Cutler (1993) found that structured group counseling decreased anxiety and enhanced the self-esteem of children who were victims of incest. Galante and Foa (1987) provided a series of interventions for children in schools who had experienced a natural disaster and found that the intervention was successful in alleviating the symptoms of stress response. Brock (1998) summarized some of the literature on group crisis intervention strategies, noting that the support and dialogue offered by group approaches promotes the healing process, reduces feelings of isolation, and develops a sense of shared experience. This process may help survivors normalize their reactions and view them as more manageable. Everly, Boyle, and Lading (1999) performed a meta-analysis of previous research on Critical Incident Stress Debriefing and conclude that it is an effective crisis intervention technique in a variety of situations (such as natural disasters and mass shootings).

Immediate Crisis Intervention

The immediate priorities after a violent event on school grounds include securing students, staff, and legitimate visitors out of harm's way; assisting the injured; requesting emergency assistance; and engaging the crisis team and plan. Implementing these actions should occur simultaneously, and, once completed, allow the crisis team to prioritize the longer-term response to meet the psychosocial needs of the school community (Trump, 2000). Additionally, crisis team members must provide psychological first aid and triage and provide immediate interventions for parents who come to the school.

Establishing safety and security. An immediate need following acts of school violence is to reestablish order and ensure the safety and security of students, staff, and visitors. In addition to ensuring physical security, these actions also begin to meet the psychological needs of persons in crisis by reducing ongoing threat perceptions. Schools should have a security plan in place as a part of their violence prevention planning (Trump, 2000). Procedures and issues to ensure safety and security issues following a crisis event have been addressed in the literature (Brock, Sandoval, & Lewis, 1996; Poland, 1997; Trump, 2000) and are summarized here.

A code should be established to allow teachers, students, and administrators to share information about the type and location of a crisis and the expected response. Schools should have a plan for both locking down the school to protect students and evacuating the school as appropriate to the specific event. Evacuation procedures usually parallel those of fire drills, and these procedures should be in writing. If evacuation plans necessitate the use of school buses to transport students off-site, a preexisting arrangement should be in place with the transportation coordinator to provide emergency transportation. If evacuation is expected to last a significant amount of time, water and food should be made available as well as shelter (such as in a neighboring church or community center).

Whether the campus is locked down or evacuated, there should be a process to account for all students and staff and report missing or injured persons to the administration. Current class lists, the absentee list, and the student accounting procedures should be available to school staff. Special procedures must be in place to inform substitute teachers of the accounting procedures in use by the school. A school official should track students who are transported to hospitals, preferably before they are transported off campus, although the school official may need to go to the local hospital(s) to establish an accurate student count.

Schools should develop procedures to reunite students with their parents or guardians. Younger students should have priority in reunification with their parents. There must be some form of documentation that the student was released to the parent or guardian to avoid misidentifying the student as missing. A simple release form to be signed by the parent/guardian and a school official when a child is released to the adult is sufficient. It is also suggested that schools identify a place where parents go for reunification. This may be a particular entrance to the school building or evacuation site.

Psychological first aid and triage. Psychological first aid is immediate assistance to provide support, minimize further destructive potential, and link the person with further helping resources (Slaikeu, 1990). The primary goal is to reestablish immediate coping by assisting the person with concrete steps to manage the crisis. In addition to its use by mental health professionals, psychological first aid can be used by others to assist students or staff in the period immediately following the violent act (Carroll, 1998; Chapters 20 and 21 of this volume provide additional discussion of immediate crisis interventions).

Another immediate task is to identify students who may require additional specialized services as a result of their exposure to the violent incident. The potential for more serious responses is related to the degree of exposure to the violent event, including proximity to the event and whether the student witnessed the injury or death. Other risk factors include the presence of previously existing psychopathology, familiarity with the victim(s), a history of previous loss or trauma, worry about safety of family members, and a nonsupportive family response (Pynoos & Nader, 1988; Chapter 19 of this book provides additional discussion on identifying psychological trauma victims). The goal of triage is to decide who needs more immediate and intensive assistance to link them with the appropriate services.

Immediate interventions with parents. School personnel are likely to have initial parental contact when panicked parents call or arrive at the school after hearing media reports of an incident at the school. Klingman (1987) provides useful guidelines for meeting the immediate needs of parents. Gathering accurate information is often the most important task when initially intervening with parents. A part of the school crisis plan should include procedures for parents to follow in case of a schoolwide disaster. Sufficient personnel must be available to answer phones to provide information to parents. If parents cannot be immediately reunited with their children, the school should provide a reception area for parents to congregate while waiting for information or to be reunited with their children. The reception area should be in an unaffected area of the school or a nearby facility with sufficient space, such as a church or recreation center. The room should be large enough for the expected number of persons, and if the potential wait will be long, providing simple refreshments is often comforting. Members of the school crisis team or other appropriately trained personnel should be available in the reception area to listen, acknowledge the difficulty of the current situation, and provide support. The crisis team members should correct misunderstandings when possible, maintain communication, and attempt to build trust between the families and the school. Crisis team members can also spot families who may be coping in a negative fashion and provide them with further assistance or referral when necessary.

The First 72 Hours

Large-group crisis intervention. Large-group interventions are advantageous because they allow crisis team members to reach a larger number of students, and the group process promotes sharing and mutual support among students. Brock (Chapter 20) outlines a process called Group Crisis Intervention (GCI) that can be used to help large groups of students following traumatic events. For a detailed discussion of this approach, refer to Chapter 20.

Small-group crisis intervention. Given the relatively high traumatizing potential of school violence, it can be expected that some students will be extremely upset about the incident and may need more attention than can be provided in larger group interventions. Weinberg (1990) suggests that students who have more risk factors can benefit from small-group intervention and are best served in groups of 4 to 12 students.

This format allows more individual attention to students, and allows closer evaluation of the students' continuing intervention needs. It is best if the students in the small groups are homogeneous in terms of age, familiarity, and level of exposure to the event. The group sessions usually last between one and two hours.

Crisis intervention groups often begin with an introduction and discussion of where students were during the incident or how they found out about the incident. Participants are then encouraged to share feelings and generate group support. Group members are asked about prior experiences of loss and trauma, and guilt and self-reproach are explored. Students are asked to brainstorm healthy coping behaviors, often focusing on concrete issues that the students will deal with in the immediate future. Closing activities take place, and students are encouraged to utilize the coping behaviors discussed in the group. If referrals are necessary, the facilitators discuss this with individual students.

Interventions for families. Families are quite diverse in terms of composition and functioning. Love, attention, and acceptance from family members are necessary for the optimum development of all children. A strong and supportive family can also provide significant help to children who are victimized (Knapp, 1998). Families are also "crime victims by extension" and can suffer greatly because of the victimization of a child (Masters, Friedman, & Getzel, 1988). Families in which a member is exposed to, or is the victim of, a violent act are likely to have psychological reactions to the event. The death of a child has a profound effect on families and changes their lives forever (Lazzara & Poland, 2001). Death by homicide is especially difficult, resulting in a prolonged bereavement (Rinear, 1988) that likely includes symptomatology similar to that of PTSD (Amick-McMullan, Kilpatrick, Veronen, & Smith, 1989). Because of these factors, intervention after a child's exposure to violence should include attention to the needs of their families.

Interventions with families range in intensity and involvement from giving information to providing support groups or psychological treatment. Some families will only need access to relatively brief informational strategies with which to ease the adjustment of the family. Information on grief and bereavement, children's reactions to trauma, and suggested caregiving behaviors are often very useful. Handouts and other printed material can be useful in providing information in an efficient manner that also allows the family to review the material as often as necessary in the future. Examples of informational handouts include several on children and trauma (Baltimore City Public School System, n.d.; Lazarus, 1998; Lazzara & Poland, 2001). Schools can make additional material available to parents through the school library, through cooperative agreements with municipal libraries, or by developing an updated list of Internet resources for parents and children.

Klingman (1987) conducted a group meeting of parents of children exposed to school violence that centered on providing information on children's responses to trauma and the types of responses to expect from other family members. Support was provided for parent's concerns, and members of the crisis team explained the principles of recovery from crisis. The remainder of the group session was devoted to a discussion of particular issues and concerns of family members, such as dealing with fears, return to routine, and facilitation of mourning. Sometimes the initial meeting with parents can be in a larger group (a schoolwide meeting), but smaller groups are usually more effective in helping parents assist their children (Pynoos & Nader, 1988).

Interventions for school staff. It is a natural reaction of school staff to put the needs of children first during a crisis situation, sometimes overlooking their own reactions or needs. School employees can suffer debilitating symptoms as a result of the trauma associated with school violence (Blackwelder, 1995). Some school employees have symptoms of PTSD lasting months or years after a traumatic event at school. An effective crisis plan, the perception of support and action from central office staff, and distance from the event were all associated with a more positive outcome for school employees (Ganz, 1996). This positive outcome points out the importance of the preventive strategy of effective planning and of immediate action and support from central administration in reducing stress on school employees after a crisis. Critical Incident Stress Management activities (Mitchell & Everly, 1996) have been used to reduce stress and encourage positive coping strategies for school personnel. Mental health support through a school system's Employee Assistance Program should also be made available to school staff when these services exist.

Long-Term Activities

Reentry issues. Members of the school community who have been affected by a violent event and been away from the school will have reentry issues (Ganz, 1996). If the event occurred at school, returning to the school after an absence is likely to elicit some of the symptoms related to the original event. It may also serve as a reminder of the event for persons in the class or school. It is often helpful to meet with the returning individuals (and, in the case of students, their families) to prepare for reentry. A discussion of feelings about the incident, hopes and fears about returning to school, and helping the returning person to anticipate their reactions on return to the school will enable the development of a plan to support the person on reentry and provide coping strategies if the feelings become too uncomfortable. A preentry visit to the school when others are not present (after school or on a weekend) may be useful in easing the return. Other students in the class (and teachers in the case of a returning student) may also benefit from discussing their expectations and fears prior to the person's return. Open discussion and preparation can smooth the transition for all affected by the returning person.

Similar reentry issues may exist when a school is evacuated and closed for a significant period of time. Payne (1999) described a process to provide a planned reentry for students whose school was closed after a shooting in Springfield, Oregon. Students and staff were given the opportunity to visit the school prior to the reopening of the school. Family, friends, and mental health providers were there to provide support to the returning members of the school community. The first day of classes following the shooting, breakfast was served in the school cafeteria and courtyard and students attended a half day of classes. Counselors were available in each classroom that day and were available for drop-in counseling through the end of the school year.

Family support. Some families need additional support over a period of time. A variety of support groups are available, especially in larger communities. Grief and bereavement groups are typically available through local hospices, hospitals, or occasionally through funeral homes. My professional experience suggests that the needs of parents who have lost a child through violence are more complex than those of persons who lost other loved ones to other causes of death. It is important to ascertain that the person leading the bereavement group has an understanding of these issues. There are also support groups for parents who have lost children, such as Compassionate Friends,[1] which provide long-term support. Many communities have Witness/Victim Support programs through which families who have been affected by violence can receive help.

A few families will need referral for more intensive intervention such as psychotherapy or family therapy. This is true of families who experienced the death of a child or for whom the crisis has precipitated serious disruption of function. These issues often require the services of a clinician who has experience in working with families after crisis. The school practitioner should be knowledgeable about the support resources available in the community and make referrals as warranted.

Group treatment. Because acts of violence are arguably one of the most traumatic types of crisis events, it would not be surprising if a relatively large number of crisis victims were to develop PTSD symptoms. Frequently, teachers are the first to notice when children demonstrate these symptoms at school, and it is important for teachers to be aware of the symptoms so that referral for group treatment can be initiated. Brown (1996) provides a group counseling format for school mental health personnel to use when counseling students with symptoms of PTSD.[2] The basis of the group is a cognitive-behavioral model that stresses restructuring cognitions and coping with the negative responses to cognitions. Techniques such as guided imagery, expressive activities, and relaxation are also part of the treatment program. The 10 sessions include: (a) explaining PTSD, (b) starting the assessment process (identifying cognitions), (c) continued assessment (identifying intrusive images), (d) continued assessment (identifying physical symptoms), (e) controlling thoughts, (f) controlling physical reactions, (g) replacing unwanted images, (h) being safe, (i) continuing to identify ways to be safe, and (j) termination.

The goals of the group are to develop strategies to control intrusive thoughts and images, deal with physical symptoms, and help children establish a sense of safety in school, home, and community. The group is aimed at children age 8 and older, although it can be adapted to use with children 5- to 7-years of age by adapting activities and using more extensive play media.

Crisis follow-up activities. One or two weeks after the event, a follow-up meeting should be held with the entire school staff to review the events, allow for ventilation of feelings, and provide further information about grief, bereavement, or adjustment to trauma. This is also a good time to check with staff to identify any students who need further intervention and to consider and plan for longer-term issues (e.g., birthdays of victims, anniversary dates, and criminal trials of perpetrators). Follow-up contacts with persons affected by a violent incident can enhance their feelings of support and connection. Phone calls, drop-in visits, follow-up meetings, and informal seminars are all potentially useful follow-up activities (Blackwelder, 1995).

A postcrisis evaluation is important to identify the strengths of the crisis response and recommend improvements in the plan or its execution. The crisis team should meet to discuss and evaluate the intervention, along with other mental health providers who assisted in the process. It is best when a trained facilitator who did not participate in the crisis intervention leads the evaluation. Recommendations can be processed and included in any revision to the school's crisis plans.

Finally, it is important to acknowledge that, given the fact that acts of violence are so traumatic, it is more likely that this type of crisis event will necessitate the need for longer-term assistance. It is essential that, as part of the follow-up activities, the school ensures such support is accessible and available to those who are in need.

Conclusion

A violent event on or near the campus can create significant reactions in individuals and the entire school system. As a social institution, the school has a significant influence on how children deal with the trauma in their lives (Ganz, 1996). While school violence shares characteristics similar to other traumatic events, some specific factors and interventions are unique to dealing with the aftermath of school violence. Having a crisis plan in place and implementing the plan effectively will go a long way toward minimizing the impact on persons involved and restoring individual and school functioning to the precrisis level. The plan should include a variety of interventions aimed at reestablishing safety, providing support and reassurance for all, and an implementing an array of more intensive interventions for those in greater need.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text rev.). Washington, DC: Author.

Amick-McMullan, A., Kilpatrick, D. G., Veronen, L. J., & Smith, S. (1989). Family survivors of homicide victims: Theoretical perspectives and an exploratory study. *Journal of Traumatic Stress, 2*, 21-35.

Amidon, B. S. (1996). PTSD in abused and traumatized children. *Dissertation Abstracts International, 56*, 3835.

Bachman, J. G., Johnston, L. D., & O'Malley, P. M. (1997). *Monitoring the future: A continuing study of lifestyles and values of youth, 1985-1995.* Ann Arbor, MI: University of Michigan Survey Research Center.

Baltimore City Public School System. (n.d.). *Childhood trauma: A parent's guide.* Available Online: 206.181.231.106/trt/parguide.html

Blackwelder, N. (1995). Critical incident stress debriefing for school employees. Unpublished doctoral dissertation, University of South Florida, Tampa, FL.

Bowen, N. K., & Bowen, G. L. (1999). Effects of crime and violence in neighborhoods and schools on the school behavior and performance of adolescents. *Journal of Adolescent Research, 14*, 319-342.

Brock, S. E. (1998). Helping classrooms cope with traumatic events. *Professional School Counseling, 2*, 110-116.

Brock, S. E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools: A manual for building school crisis response teams.* Brandon, VT: Clinical Psychology.

Brown, D. (1996). Counseling the victims of violence who develop posttraumatic stress disorder. *Elementary School Guidance and Counseling, 30*, 218-227.

Carter, S. P., & Stewin, L. L. (2000). School violence in the Canadian context: An overview and model for intervention. *International Journal for the Advancement of Counselling, 21*, 267-277.

Carolina Population Center. (1997). *National longitudinal study of adolescent health: Wave I adolescent in-home questionnaire.* Atlanta, GA: Centers for Disease Control.

Carroll, S. A. (1998). Emotional first aid. In A. S. Canter & S. A. Carroll (Eds.), *Helping children at home and at school: Handouts from your school psychologist* (pp. 515-516). Washington, DC: National Association of School Psychologists.

Centers for Disease Control and Prevention. (1997). *Youth Risk Behavior Surveillance-United States, 1995.* Atlanta, GA: Centers for Disease Control and Prevention.

Chandras, K. V. (1999). Coping with adolescent school violence: Implications for counseling. *College Student Journal, 33*, 302-312.

Cornell, D. G., & Sheras, P. L. (1998). Common errors in school crisis response: Learning from our mistakes. *Psychology in the Schools, 35*, 297-307.

DeLuca, R. V., Hazen, A., & Cutler, J. (1993). Evaluation of a group counseling program for preadolescent female victims of incest. *Elementary School Guidance and Counseling, 28*, 104-114.

Everly, G. S., Boyle, S. H., & Lading, J. M. (1999). The effectiveness of psychological debriefing with vicarious trauma: A meta-analysis. *Stress Medicine, 15*, 229-233.

Furlong, M. J., Kingery, P. M., & Bates, M. P. (2001). Introduction to the special issue on the appraisal and prediction of school violence. *Psychology in the Schools, 38*, 89-91.

Galante, R., & Foa, D. (1987). An epidemiological study of psychic trauma and treatment effectiveness after a natural disaster. In S. Chess & A. Thomas (Eds.), *Annual progress in child psychiatry and child development* (pp. 349-364). Philadelphia, PA: Brunner/Mazel.

Ganz, J. J. (1996). *Trauma in school communities: How schools cope with the impact of trauma.* Unpublished doctoral dissertation, University of Pennsylvania, Philadelphia, PA.

Garbarino, J., Dubrow, N., Kostelny, K, & Pardo, C. (1992). *Children in danger.* San Francisco: Jossey-Bass.

Garbarino, J., & Kostelny, K. (1997). What children can tell us about living in a war zone. In J. D. Osofsky (Ed.), *Children in a violent society* (pp. 32-41). New York: Guilford Press.

Hennes, H. (1998). A review of violence statistics among children and adolescents in the United States. *Pediatric Clinics of North America, 45*, 269-280.

Hyman, I., Weiler, E., Perone, D., Romano, L., Britton, G., & Shanock, A. (1997). Victims and victimizers: The two faces of school violence. In A. P. Goldstein & J. C. Conoley (Eds.), *School violence intervention: A practical handbook* (pp. 426-459). New York: Guilford Press.

Jenkins, E. J., & Bell, C. C. (1994). Violence exposure, psychological distress, and high risk behaviors among inner-city high school students. In S. Friedman (Ed.), *Anxiety disorders in African Americans* (pp. 76-88). New York: Springer.

Jenkins, E. J., & Bell, C. C. (1997). Exposure and response to community violence among children and adolescents. In J. D. Osofsky (Ed.), *Children in a violent society* (pp. 9-31). New York: Guilford Press.

Kingery, P. M., Coggeshall, M. B., & Alford, A. A. (1998). Violence at school: Recent evidence from four national surveys. *Psychology in the Schools, 35*, 247-258.

Klicker, R. L. (2000). *A student dies, a school mourns.* Philadelphia, PA: Accelerated Development.

Klingman, A. (1987). A school-based emergency crisis intervention in a mass school disaster. *Professional Psychology: Research and Practice, 18*, 604-612.

Klingman, A. (1993). School-based intervention following a disaster. In C. F. Saylor (Ed.), *Children and disasters* (pp. 187-210). New York: Plenum Press.

Knapp, J. F. (1998). The impact of children witnessing violence. *Pediatric Clinics of North America, 45*, 355-364.

Lazarus, P. J. (1998). Trauma and children: A parent handout for helping children heal. In A. S. Canter & S. A. Carroll (Eds.), *Helping children at home and at school* (pp. 292-296). Washington, DC: National Association of School Psychologists.

Lazzara, K. C., & Poland, S. (2001). Managing crisis: Intervention skills for parents. In M. J. Fine & S. W. Lee (Eds.), *Handbook of diversity in parent education* (pp. 339-372). San Diego, CA: Academic Press.

Marans, S. (1994). Community violence and children's development: Collaborative interventions. In C. Chiland & J. G. Young (Eds.), *Children and violence* (pp. 109-124). Northvale, NJ: Jason Aronson.

Masters, R., Friedman, L. N., & Getzel, G. (1988). Helping families of homicide: A multidimensional approach. *Journal of Traumatic Stress, 1*, 109-125.

McKibben, L., DeVos, E., & Newberger, E. (1989). Victimization of mothers of abused children: A controlled study. *Pediatrics, 84*, 531-535.

McLean, M. M. (1996, January). It's a "blackboard jungle" out there—Or is it? *The Education Digest, 61*(5), 4-8.

Mitchell, J. T., & Everly, G. S. (1996). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers*. Ellicott City, MD: Chevron.

Ozer, E. M., Brindis, C. D., Millstein, S. G., Knopf, D. K., & Irwin, C. E. (1997). *America's adolescents: Are they healthy?* San Francisco: University of California.

Payne, C. (1999). Tragedy response and healing—Springfield unites. In A. S. Canter & S. A. Carroll (Eds.), *Crisis prevention and response: A collection of NASP resources* (pp. 187-190). Washington, DC: National Association of School Psychologists.

Poland, S. (1997). School crisis teams. In A. P. Goldstein & J. C. Conoley (Eds.), *School violence intervention: A practical handbook* (pp. 127-157). New York: Guilford Press.

Poland, S., & McCormick, J. S. (2000). *Coping with crisis: A quick reference*. Longmont, CO: Sopris West.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, E., Steinberg, A., Eth, S., Nunez, F., & Fairbanks, L. (1987). Lifethreat and posttraumatic stress in schoolage children. *Archives of General Psychiatry, 44*, 1057-1063.

Pynoos, R. S., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*, 445-473.

Rinear, E. E. (1988). Psychosocial aspects of parental response patterns to the death of a child by homicide. *Journal of Traumatic Stress, 1*, 305-322.

Sieckert, K. (1998, November). Cultural perspectives on trauma and critical response. NASP *Communiqué, 27*(3), 30-31.

Singer, M. I., Anglin, T. M., Song, L. Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association, 273*, 477-482.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Boston: Allyn & Bacon.

Taylor, L., Zuckerman, B., Harik, V., & Groves, B. M. (1994). Witnessing violence by young children and their mothers. *Journal of Developmental and Behavioral Pediatrics, 15*, 120-123.

Trickett, P. K., & Schellenbach, C. J. (1998). Introduction. In P. K. Trickett & C. J. Schellenbach (Eds.), *Violence against children in the family and the community* (pp. 3-8). Washington, DC: American Psychological Association.

Trump, K. S. (2000). *Classroom killers? Hallway hostages? How schools can prevent and manage school crises*. Thousand Oaks, CA: Corwin Press.

U.S. Department of Education & U.S. Department of Justice. (1999). *Annual report on school safety*. Washington, DC: Author.

U.S. Department of Education & U.S. Department of Justice. (2000). *Annual report on school safety*. Washington, DC: Author.

U.S. Department of Justice. (1997). *National Crime Victimization Survey: School Crime Supplement, 1995*. Washington, DC: Bureau of Justice Crime Statistics.

Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions following trauma at school. *Professional Psychology: Research and Practice, 21*, 271-278.

Endnotes

[1] Compassionate Friends is an organization devoted to providing support to persons who have lost a child. Information about the organization and its local chapters can be obtained at *www.compassionatefriends.org* or by writing The Compassionate Friends, P. O. Box 3696, Oakbrook, IL, 60522-3696.

[2] It is important to acknowledge that while most school personnel may, with sufficient training, be appropriate providers of immediate psychological first aid, this is not the case when responding to the severely traumatized. For example, the crisis intervention response for students who have developed PTSD must be provided by a mental health professional with appropriate training and experience.

危機

25

Child Maltreatment

Linda Webster, Ph.D.
Jody Browning, M.A.
University of the Pacific

You are the school-based mental health professional for a Primary Intervention Project (PIP) in an ethnically and socioeconomically diverse suburban area. PIP targets children who are assessed to be at low to moderate risk for academic and social-emotional problems that may negatively impact the child's school success. Paraprofessionals are hired and trained to be "special friends" and work with the child in a nondirective and supportive play environment. One of the paraprofessionals whom you supervise knocks on your door frantically, interrupting a testing session. A 7-year-old Hispanic girl, whom she has been seeing, has just disclosed clear and graphic sexual abuse by her 15-year-old brother.

Child maltreatment presents a complex and challenging crisis to school personnel. Although less sensationalized than other traumatic events such as school shootings, it is a prevalent and insidious crisis. In 1997, just under one million children were abused or neglected (U.S. Department of Health and Human Services, 1997). The national rate of victimization was 13.9 per 1,000 children in the population, as compared, for example, to the crisis of suicide, which has a rate of 9.47 per 100,000 15- to 19-year-olds (Peters, Kochanek, & Murphy, 1998). More than half of all child victims suffered neglect, while almost a quarter (24%) were victims of physical abuse.

Four types of maltreatment are defined in both federal and state legislation: physical abuse, neglect, sexual abuse, and emotional abuse. *Physical abuse* is characterized by the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking, or otherwise harming a child. *Neglect* is characterized by failure to provide for the child's basic physical, educational, and emotional needs. *Sexual abuse* includes fondling a child's genitals, intercourse, incest, rape, sodomy, exhibitionism, and exploitation through prostitution or the production of pornographic materials. *Emotional abuse* includes acts or omissions by the parents or other caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders. Emotional abuse is often difficult to substantiate and, thus, has been less studied, although it is considered to be one of the most damaging forms of maltreatment (Egeland & Sroufe, 1981).

Unique Crisis Issues

Effects

As defined in Chapter 1, a crisis state exists when an actual or perceived threat of danger overwhelms a person's usual coping ability (Brock, 2002). Children respond differently to situations that are highly stressful. Some children are able to cope well with a stressor, while others may be completely overwhelmed. What constitutes a traumatic event for a given child must be based on the child's experience, and not on an adult's perceptions. Children's responses to trauma are often complex because of the vulnerabilities of childhood, as well as the fact that they are still developing. Table 1 describes some of the psychological effects manifested by children who have experienced maltreatment.

Many of the symptoms described in Table 1 are similar to the diagnostic criteria for posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994); however, "the distinctions between persons with a normal stress reaction and those with PTSD are blurred, particularly soon after the event" (McFarlane, 1990, p.71). Estimates indicate that approximately 36% of children exposed to traumatic events are later diagnosed with PTSD (Fletcher, 1996). Naturally, this causes one to wonder what protective factors appear to operate for the remaining 64% who are exposed, but who do not develop PTSD.

The child in the introductory scenario exhibited some of the symptoms from Table 1. She experienced a flashback while describing the abuse to the PIP paraprofessional. This flashback occurred as an intrusive physical reaction in which the child began spitting when describing how her brother would force her to copulate him orally. Following her disclosure, she became very frightened and withdrawn, and refused to speak with the child protective services investigator. Not all children react with such clear symptomatology, and some are quite constricted in affect in an attempt to keep their emotions under control.

The large research literature on child abuse and neglect indicates a plethora of negative developmental outcomes for maltreated children. For example, studies have found an increase in depressive symptomatology in maltreated children (Kazdin, Moser, Colbus, & Bell, 1985; Toth, Manly, & Cicchetti, 1992) as well as increased aggressive behavior problems (Lyons-Ruth, 1996), atypical social development (Crittenden, 1989), cognitive delays (Crittenden, 1985), and language delays (Plough, 1985). Maltreated children experience more negative family relationships, and as parents themselves, they are at increased risk of maltreating their own children (Egeland, Jacobvitz, & Papatola, 1987; Kaufman & Zeigler, 1987).

Table 1

Psychological and Behavioral Effects of Child Maltreatment

Symptom	Description
Disorganized thinking	Children may evidence disorganization in their thinking and speech. They may have difficulty communicating effectively and cohesively, and may appear confused and/or illogical (James, 1994).
Preoccupation with insignificant activities	In an attempt to manage their anxiety, some children may exhibit a preoccupation with unimportant and concrete details, such as finishing a math assignment. In the child's mind, he or she may believe that this act may return them to a prior, more balanced state of being (Gil, 1996).
Persistent fear state	Flight, fight, and freezing are immediate and automatic survival responses that serve to protect the individual from harm. Since physical flight is often not possible for children, many "flee" by dissociating (Sroufe, 1997). Children who are repeatedly exposed to traumatizing experiences may develop a persistent fear state, with the associative responsive behaviors of hypervigilance, heightened startle response, increased irritability, anxiety, physical hyperactivity, and extreme regressive behaviors (James, 1994).
Flashbacks	The sudden, spontaneous reexperiencing of all or a part of a traumatizing event is commonly called a flashback. Flashbacks can be stimulated by associative cues, which include sensory experiences (hearing, touch, taste, smell, or sight); behavioral interactions or sequences; specific objects in the environment; or they may be triggered by internal affective states (e.g., the child becomes anxious and at the same time feels vulnerable). Flashbacks may take the form of physical sensations, feelings, behavioral reenactments, or visual images that intrude into the child's awareness (Terr, 1989; 1991).
Dysregulation of affect	Children who experience chronic trauma may experience significant difficulty with the regulation of affect. It appears that they attempt to control the intense frightening emotions they experience by "numbing" or "avoidance." Thus, these children may exhibit a constricted and flat range of affect, combined with out-of-control emotional outbursts that seem disproportionate to the stimulus (James, 1994).
Avoidance of intimacy	Emotional closeness may lead to feelings of vulnerability and loss of control, which is intolerable to the traumatized child. Intimacy thus represents a threat, not safety. Hyperactivity, lack of eye contact, withdrawal, oppositional behavior, anger, hurtful comments, and behaviors that are repulsive to others may all be used in the service of avoiding intimacy and keeping others at bay (James, 1994).

BEST COPY AVAILABLE

Mediators

Research and clinical experience (see Tower, 1999, and Webb, 1999, for reviews) suggest that several factors may mediate the impact of any type of abuse on children. These mediators include the following:

The age of the child at the time of abuse. There is general agreement that the younger the child at the time of the abuse, the more vulnerable the child is to damage. This is mitigated, however, by the quality of the child's relationships with primary caregivers before and following the abuse.

The type and severity of abuse. The more extensive the abuse, the greater the likelihood of damage. Physical abuse, which results in permanent physical damage such as physical handicaps, loss of limbs, and brain damage, is clearly more destructive and will have a prolonged negative impact on development. Likewise, severe neglect, which results in nonorganic failure to thrive, loss of bone mass, and severe dental decay poses a greater threat to the child's well-being. In sexual abuse cases, increased genital contact such as penetration is associated with greater damage.

The relationship to the perpetrator. The closer the relationship between the perpetrator and the child, the greater the potential for damage. The more that the child trusts the perpetrator and expects to be cared for by him or her, the greater the sense of betrayal, and the greater the damage. In general, victims of family incest appear to be more impacted than those who were abused by someone outside the family, but even when the perpetrator is an outsider, the closer the relationship the child has with the perpetrator, the greater the potential for damage.

The duration or chronicity of the abuse. In general, the more chronic the abuse, the greater the impact upon the child. The exception to this is short-term duration events that involve violence or sadism. The consensus is that abuse that spans a long period has an opportunity to disrupt more of the child's development and creates more distorted defense mechanisms, such as dissociation.

The emotional climate and reactions of the family members. If the family members do not believe the child, this can significantly increase damage because the child now has a sense of betrayal from the perpetrator and the trusted adult whom they hoped would help. Conversely, when adults respond swiftly, the trauma's impact is lessened. The psychosocial environment provided by significant adults (which can include teachers and counselors) can serve as a restorative factor.

The child's mental and emotional health. Personality and temperament factors, as well as self-esteem and secure attachments, are recognized resilience factors that help children cope with adversity. Children who are already compromised by significant stressors are at increased risk for poorer outcomes.

The child in the introductory scenario had a number of mediating factors present, which unfortunately served as risk, rather than protective, factors. Her brother had forced her to perform oral copulation as well as engage in sexual intercourse—both acts that are quite intrusive and damaging. The facts that the perpetrator was her older brother, and in a position of trust, increased her sense of betrayal. It was unclear how long the abuse lasted, but it was more than a one-time event. Finally, once the abuse was disclosed her family did not believe her. These factors combined to place this child at serious risk for the development of a mental disorder in later years (Sroufe, 1997).

Developmental Issues

Child maltreatment is a complex and heterogeneous phenomenon that involves multiple and overlapping etiologies, which in turn interact to influence developmental outcomes. Because these factors interact to mediate the effects of maltreatment, and because they have yet to be systematically studied, the effects upon the child's development must be considered from a range of outcomes or developmental trajectories, and thus cannot be neatly categorized into discrete outcomes. Bowlby (1988) has conceptualized a model of "developmental pathways" in which the particular pathway being followed at any given point in time is determined by the interaction of the personality as it has thus far developed, prior adaptation, and the current environmental circumstances. The emphasis is on patterns of adaptation and/or maladaptation that precede a crisis and/or the emergence of specific symptoms and/or overt psychopathology. Thus, the age of the child, and the extent to which he or she has been on a normal developmental pathway (and would thus be expected to have adequate resources and coping skills for that age), interacts with the severity, intensity, and frequency of the traumatic event and the defensive processes most commonly utilized by the child (Bowlby, 1969, 1982). Following this model, multiple potential outcomes or developmental pathways may ensue from child maltreatment.

Attachment

Bowlby also proposed the existence of an "internal working model" of attachment that is based on actual experiences the child has with the primary caregiver. Through interactions with the primary caregiver, the child develops expectations and understandings about relationships. These mental representations of relationships become internalized to the extent that they automatically and unconsciously influence feelings, thoughts, and behaviors (Bowlby, 1969, 1982; Main, Kaplan, & Cassidy, 1985). However, these models are also open to modification based upon experience and/or development (Main, 1995). In the case of a secure attachment, the child develops a model that generates expectations that others will be responsive and accessible and, in general, the child develops positive and trusting attitudes toward others. They learn to value relationships and construct an internalized template for empathy and reciprocity (Sroufe, 1997). Children with secure attachments learn to recognize and effectively modulate their own emotions, they develop social empathy and are more effective at social interactions, and they cope better with stress and frustration (Fahlberg, 1991). Viewed another way, their defensive processes allow them to flexibly integrate attachment-related experiences and transform their fears into successful resolution (Solomon, George, & DeJong, 1995). Conversely, rejection, neglect, unavailability, and maltreatment on the part of the caregiver produce insecure internal working models, which generate expectations that others are untrustworthy and the self is unworthy of love and sensitive treatment. According to the conceptual framework, the experience of maltreatment during childhood may lead to the development of negative representational models of attachment figures, the self, and the self in relation to significant others (Cicchetti, 1991; Crittenden & Ainsworth, 1989). Attachment experiences have been identified and classified into four types:

Secure. Children with secure attachments have experienced caregiving that is sensitive and responsive. This caregiving allows them to develop positive internal working models and an expectation that relationships are based on mutuality and reciprocity. If a securely attached child experienced maltreatment (from an individual other than a primary caregiver), and the primary caregiver remained sensitive and responsive to the needs of the child (which would include the need to resolve the trauma effectively), then the child would be expected to integrate the event successfully and follow a secure developmental pathway.

For the secure child who experiences maltreatment from a primary caregiver, the scenario might be different. Most children form attachments with one or both of their parents; however, this does not preclude the possibility that the child may form an attachment with another adult such as a grandparent, aunt, or even a teacher. Thus, some children who have experienced a trauma such as maltreatment from a parent may nevertheless be able to form close relationships with other responsive adults and thus shift the developmental trajectory toward a normal pathway.

Naturally, the duration and intensity of the abuse mediate the child's ability to successfully resolve the abuse, but a secure attachment acts as a protective factor influencing the child's ability to cope with and resolve crises. It is interesting to note that the proportion of children who do not develop PTSD following exposure to trauma (Fletcher, 1996) matches the proportion of secure infants in low-risk populations (van Ijzendoorn & Bakermans-Kranenburg, 1996).

Ambivalent. Children with histories of ambivalent attachment relationships may have experienced care that was unpredictable, neglectful, and/or unreliable. In middle-class, low-risk populations, such relationships may not pose a significant risk factor. However, in high-risk, maltreated populations, these children may learn that they can never quite trust that their parents will be available or will be able to respond appropriately or effectively (Howe, 1998). The child may develop an internal working model of others as uninterested and unavailable and of self as uninteresting and ineffective. Because of their fears of abandonment and rejection, they quickly form close relationships, often without discrimination, which may place the ambivalent child at higher risk for being seduced into an abusive relationship with an adult who promises love and acceptance. Traumatic maltreatment experiences are in turn likely to result in increased anxiety and increased concern with the availability of significant others, which may manifest itself in behaviors that are anxious and fretful, demanding, clinging, insistent, and angry.

Avoidant. Children with avoidant attachment styles may have experienced caregivers who are emotionally unresponsive, rejecting, and in some cases actively punishing or hostile of the child's affective expressions of need. Consequently, these children quickly learn to ignore or suppress feelings of anxiety, and attempt to become "emotionally self-reliant" (Bowlby, 1988). Again, in middle-class, low-risk populations avoidant attachment does not seem to be associated with psychopathology; however, when combined with maltreatment it becomes a significant risk factor (Sroufe, 1997). Children with avoidant attachments avoid closeness and intimacy, which they see as dangerous and potentially hurtful. Consequently, these children have poor levels of social understanding and little or no empathy (LaFreniere & Sroufe, 1985). The internal working model of these children results in the perception that others are unavailable, controlling, and rejecting, and the self is unlovable and "bad."

Avoidant children who experience maltreatment might be expected to evidence increased acting out behavior or extreme inhibition and withdrawal as a means to cope with (avoid) the anxiety that the trauma produces. In this respect it is perhaps a more efficient defensive strategy (than that utilized by the ambivalent organization) because affective needs are simply deactivated at the source—and thus require no further attention (Solomon et al., 1995).

Both avoidant and ambivalent forms of attachment appear to defend against attachment anxiety by using information-processing (or defensive) strategies that allow them to exclude certain kinds of information from consciousness (Solomon et al., 1995). These strategies serve to modulate painful feelings and allow children to continue to be involved in their environment. As such, they are considered "organized" approaches.

Insecure-Disorganized. Children classified as disorganized experience unpredictable, dangerous environments, and experience the caregiver as frightening (Main & Hesse, 1990). They face a paradoxical situation in which they are afraid of the very person they naturally and instinctively seek reassurance from, resulting in what Main (1995) refers to as a state of "fright without solution." This results in a collapse of behavioral strategies for dealing with stress. Behavioral manifestations may include freezing, self-injurious behavior, and/or obvious signs of fear and anxiety. These children experience a "dysregulation" of affect in which they are unable to either defend against or resolve attachment anxiety (Solomon et al., 1995). If a child is given a primary classification of disorganized, he or she is *also* assigned the best-fitting alternative from among the other three classifications. Some researchers have reported that 80% of parent-child relationships in maltreatment samples are classified as insecure-disorganized (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Lyons-Ruth, Connell, Grunebaum, & Botein, 1990; Lyons-Ruth, Repacholi, McLeod, & Silva, 1991; O'Conner, Sigman, & Brill, 1987).

Two longitudinal, prospective studies have shown that disorganized behavior in infants shifts to controlling behavior at six years of age (Main & Cassidy, 1988; Wartner, Grossman, Fremmer-Bombik, & Suess, 1994). Children are deemed to be "controlling" if they "seem to actively attempt to control or direct the parent's attention and behavior and assume a role which is usually considered more appropriate for a parent with reference to a child" (Main & Cassidy, 1988, p. 418). It is presumed that the child develops this "controlling" behavior in response to the unpredictability of the parent and the fears associated with the parent's behavior. Correlates of disorganized and "controlling" behavior include oppositional behavior (Greenberg, DeKlyen, Speltz, & Endriga, 1997), externalizing behavior (Hubbs-Tait, Osofsky, Hann & Culp, 1994), low self-confidence, problems with deductive reasoning (Jacobsen, Edelstein, & Hoffman, 1994) and dissociation at 16 to 19 years of age (Carlson, 1998; Ogawa, Sroufe, Weinfeld, Carlson, & Egeland, 1997).

Cultural Issues

Effective intervention and prevention with culturally diverse populations necessitates several areas of expertise (American Psychological Association, 1993). School personnel must become aware of the predominant cultures that they serve and must become knowledgeable about those cultures without overgeneralizing and thus losing the individual. Working in minority communities necessitates becoming familiar with and respecting indigenous beliefs and practices. One must also guard against the assumption that because an event takes place within a cultural context it is normal. For example, the first author was once presented with a case of child abuse from a Sri Lankan family in which the father forced the children to hold heavy piles of books on their outstretched arms at a perpendicular angle for several hours as a form of punishment for disobedience. Although the father argued that this was a common cultural practice of discipline, the Sri Lankan social caseworker assigned to the case stated that this was not true.

In addition to becoming knowledgeable, obtaining training, or using consultants, professionals must always be alert and aware of their own values and attitudes and how they may impact their relationship with the child and family of a different culture. In the case of language barriers, efforts must be made to obtain an interpreter or make an appropriate referral.

Prior experiences in their native countries may also significantly impact interactions of families in this country with "government" officials. For example, individuals who have come from countries with totalitarian governments may be extremely suspicious of any governmental representative (including teachers and counselors). Thus, it is important to remain aware of sociopolitical contexts and to develop sensitivity to issues of oppression, sexism, elitism, and racism.

A cultural emphasis on family cohesion may mean that the family would rather ignore or discount the abuse, pressuring the child to recant or maintain silence, than to be separated. Sometimes the family is financially or otherwise dependent upon the abuser, and the alternative is perceived as being worse than tolerating the abuse. Some Asian cultures may feel the need to deny the abuse at any costs in order to save face. Finally, many cultures may employ an indirect communication style, and the children may not be able to express their feelings and describe their experiences directly.

Crisis Prevention

School-based prevention efforts have tremendous potential to reduce the number of children victimized (Daro, 1991; Oates, 1996; Tower, 1999). Because most children attend school, school-based prevention programs reach a majority. Examples of crisis prevention strategies and programs include the following:

Coping With Crisis/Self-Protection Training

Prevention programs that give the child permission to talk about abuse and neglect and that help the child to understand what to do if abuse is occurring are beneficial. Although it can be argued that the child is frequently not in a position to behave assertively, offenders report that a child's threat to tell someone would have the greatest impact on deterring abuse (Conte, Wolf, & Smith, 1989).

The various prevention programs now available to schools (Tower, 1984, 1999) aim to (a) educate children about abuse, (b) make children aware of potential abusers, and (c) teach children what action to take in abusive situations. Prevention efforts emphasize that children have a right not to be hurt and that children who have been abused should tell a trusted adult. Since most prevention programs encourage children to tell a trusted adult such as a teacher, it is critical that teachers are comfortable with and receptive to a child's efforts to disclose, and that teachers know what to do with the information. In this regard, in-service training from the school-based mental health professional can be very helpful (Tower, 1999).

Teen Education

Curricula that focus on child development, positive discipline techniques, child health issues, and prevention of accidental childhood injuries provide adolescents with the knowledge and skill to be effective caregivers. Curriculum should include information about appropriate and inappropriate touching and how to cope with the anger and stress associated with being a caregiver. Since children with special needs (such as a child with a physical or mental disability) are at higher risk for abuse, the curriculum should specifically address how to care effectively for such children. Teen parents are at higher risk for becoming perpetrators of abuse (Tower, 1999), because they are frequently under more life stress and have fewer parenting skills. Relationship-based intervention projects (see Leiberman & Zeanah, 1999, for a review), which focus on the identification of strengths in the mother-infant relationship, may be modified for use in the schools with teen parents and their children. Results of these projects have shown improvements in maternal empathy and child behavior problems. Although true experiments have yet to be employed to study these prevention efforts, research examining their effects on abusers has shown them to prevent further abuse (e.g., Wolfe, Sandler, & Kaufman, 1981).

Community Involvement

School success requires more than formal, specialized, or categorical services. It requires strong relationships among informal helping networks, including church, family support services, youth development programs, mentoring, and recreational opportunities to name a few. Schools are prominent, safe, and accessible institutions in the community and as such are likely to house and sponsor community activities. As the person with the psychological knowledge base, the school counselor, social worker, or psychologist is in a strong position to articulate and coordinate these relationships. This assertion is in keeping with the National Association of School Psychologist's Blueprint II (Ysseldyke, Dawson, Lehr, Reschly, Reynolds, & Telzrow, 1997) "schools as caring communities." Schools are a natural base for community prevention activities. Schools can provide adult education in child development, parenting skills, budgeting, stress reduction, and effective coping skills to help parents become more effective as adults and less likely to abuse. In addition, special courses and support groups for parents of disabled children may be especially helpful.

Many of these "courses" may already be offered through a city's parks and recreation programs. It may just be a matter of requesting that these services be offered at the school site to be more convenient for families. Another avenue is to work collaboratively with local social services departments to focus on prevention and/or early intervention activities.

Crisis Intervention

Legislation mandates the identification and reporting of child maltreatment to designated social service or law enforcement agencies. States have enacted their own laws and identified specific professionals who are required to report suspected child abuse and neglect. However, all such laws include school personnel as mandated reporters. Most states also indicate a time period in which reports must be made. While the obvious goal of these laws is to stop child maltreatment, they also place additional stress on both the child and the reporter. Mandated reporters must approach these situations with care and sensitivity.[1]

In the scenario introduced at the beginning of this chapter, the school psychologist informed the paraprofessional that a report must be made immediately. While the psychologist made the phone call, the paraprofessional returned to inform the child of the procedure. The child became very withdrawn, and when the investigator arrived, although he was quite skilled in working with children, the child refused to disclose any maltreatment. In the meantime, the school day had ended and the child's parents were informed that a child protective services investigator was detaining the child. The parents became very angry and verbally abusive with the school personnel for making the report. After they were informed of the school's legal responsibility, they eventually calmed down.

Although the district attorney had the option to prosecute, in this particular case charges were not pressed against the brother. Although the parents refused to believe the allegations, at the direction of social services, they did move the brother into the home of a relative. The child returned to school, but was taken out of the PIP program by the parents. The child refused to speak to, or acknowledge, the paraprofessional following her disclosure. This case serves to demonstrate the complexity and unpredictability of many child maltreatment cases. Cases such as these can be frustrating, but they also emphasize the importance of the provision of indirect services to these children, because direct services may be denied them.

Direct Interventions

The goal of immediate crisis intervention is to preclude later symptom development by helping children to express their feelings, lessen their distress, and reinforce coping strategies before inappropriate defensive mechanisms can become entrenched and lay the foundation for future emotional and functional difficulties (Webb, 1999).

For some children, disclosure itself and the events that follow are more traumatizing than the actual maltreatment. Regardless of the efforts taken to minimize the negative impact of a child abuse report, the child's sense of vulnerability and regret will frequently be increased as a result of disclosure, particularly if the perpetrator is someone to whom the child feels close to or depends on. School professionals must be sensitive to the child's predicament and resist using false reassurances (e.g., "Everything will be better once you've talked about it," or "Everything will be okay"). As the uncertainty of the process and procedure may be anxiety-provoking in and of itself, it may be helpful to discuss what will occur. Knowing what to expect can reduce anxiety. The following are general guidelines for immediate crisis intervention with maltreated children.

Meet the reporting requirement. Regardless of whether or not the child's story is believable, if the professional has "reasonable suspicion," it must be reported as soon as possible.

Emphasize the current crisis and be directive. Focus on the immediate welfare of the child. Arrange for the child's belongings to be brought to him or her. Address the child's concerns about schoolwork, homework, recess, etc. Make sure that the child's physical needs are addressed (hunger, thirst, etc.).

Reduce blame in the victim. Emphasize to the child that he or she is not responsible for the abuse, and that the problem sometimes occurs in other families.

Clarify thoughts and feelings. Restate and paraphrase the child's thoughts and feelings in order to demonstrate understanding and acceptance. Validate positive behaviors such as the disclosure. Provide emotional support with reassurance, encouragement, and sympathetic listening to reduce tension and guilt. Use warmth and display knowledge of abusive families so that the child feels comfortable and safe.

Maintain a neutral attitude. Adopt a posture of calm and supportive acceptance of the child's disclosure. Avoid words, gestures, or expressions that convey anger, disapproval, or shock. Avoid interpretations or accusations.

Provide information. Provide the child with developmentally appropriate information about the reporting process, the role of the police, child protective services, and the courts, etc. Information about what to expect can help to reduce anxiety.

Most clinical leaders in the field of child maltreatment argue that the mental health professional must focus directly on the experience of maltreatment (Gil, 1996; James, 1994; Webb, 1999). The trauma must be reworked, either directly through verbalization of details, emotions, and memories, or indirectly through play or symbolic means. Terr (1983) advocates for verbalization, as well as therapeutic play, for the severely traumatized child. Pearce and Pezzot-Pearce (1997) describe a three-step process of treatment that first involves helping children to acknowledge the fact of the maltreatment and helping them to recognize, identify, and express their feelings and thoughts regarding the abuse. The length of time of this aspect of therapy may depend upon the defensive processes of the child. The securely attached child may find it easier to access his or her emotions and thoughts about the abuse, and thus this may be a relatively straightforward task for the counselor. The avoidant child may steadfastly resist discussions surrounding the abuse and may ultimately deny any impact on the self by the abuse. The ambivalent child may likewise resist discussions about the abuse, but may employ more distraction techniques such as talking effusively about other unrelated details, or may insist that he or she is really very happy. Disorganized children may become constricted and refuse eye contact or discussion, or their play may contain themes of chaos or violence without necessarily referencing the abuse (Solomon et al., 1995).

In their second stage of therapeutic intervention, Pearce and Pezzot-Pearce (1997) advocate helping children adopt more adaptive ways of expressing their feelings regarding the maltreatment. Children who have been maltreated often have trouble with affect regulation (James, 1994), and these children can benefit from relaxation exercises, positive self-statements, self-monitoring, and problem-solving skills (Pearce & Pezzot-Pearce, 1997). Children who dissociate as a result of abuse can be taught to identify and moderate (or terminate) dissociative states (Gil, 1996).

In their final stage of therapeutic intervention, Pearce and Pezzot-Pearce (1997) argue that children need to move from a "victim" posture to one of mastery and power. The counselor helps the child to accomplish this by developing realistic protection strategies, including, most frequently, telling a trusted adult.

Throughout the process of therapy or counseling one of the goals of treatment, from an attachment perspective, is to modify the child's negative internal working model of others as hostile and negative. This goal is accomplished within the therapeutic relationship over time as the child experiences the therapist or counselor as a caring and nonabusive adult upon whom they can rely (Pearce & Pezzot-Pearce, 1997).

Indirect Interventions

Promote academic success. The developmental pathways model suggests that change is possible at many points. Successful mastery of important developmental tasks can be profoundly healing to these children and can potentially influence the path of development back toward normality (Sroufe, 1990; 1997). Viewed from the pathways perspective, mastery experiences in both the cognitive and social-emotional domains are important. For example, academic achievement and the development of appropriate, peer relationships can be "normalizing" experiences for maltreated children (and others for that matter). In fact, some abused children state that school was the only place where they felt "normal" and "safe." Thus, a focus on the creation of developmentally appropriate curriculum that is relevant and meaningful to the learner, that connects what is being learned with the learner's existing cognitive and social resources, and that occurs in an environment that contains positive interpersonal relationships and interactions should prove beneficial to maltreated children whose development may be diverging from the normal pathway (Lambert & McCombs, 1998).

Another issue directly related to academic success, but frequently overlooked in practice, is the issue of the stability of adult-child contact. Optimally, we would wish to maximize the stability of the contact between a child and teacher (Pianta, 1999) because this provides a regulatory function for the child's development, which may serve to enhance learning. In fact, Pianta (1999) argues that practices such as resource and other "pull-out" programs actually serve to undermine the effectiveness of the child-teacher relationship and the child's learning. Thus, consultation with teachers that promotes the implementation of developmentally appropriate curriculum, as opposed to qualifying the child for special education, may in the long haul provide more opportunity for maltreated children (and others) to succeed academically.

Promote positive and productive peer relationships. As previously stated, maltreated children are at higher risk for developing inappropriate peer interactions, ranging from withdrawn and avoidant to physically aggressive and inappropriate sexual behavior. The school-based mental health professional is in a position to intervene with problematic behaviors as they occur, hopefully modifying behavior problems before they escalate and/or stigmatize the child. Techniques such as conflict-resolution and enhancing social problem-solving skills, which are useful for all children, may be especially important for the maltreated youngster. The school-based mental health professional can play a key role in developing schools that promote an atmosphere of respect and acceptance of individual differences, as well as a valuing of positive interpersonal relationships. In fact, Sroufe (1997) argues that resilience is a *process* of ensuring supportive relationships through childhood and even into adulthood.

Promote appropriate adult-child relationships. Relationships at every level, from teacher to principal to school to school district, become an opportunity to mitigate negative, punishing, and painful experiences. For example, interventions that focus on the people in the system (teachers in particular) have been shown to promote student motivation and achievement (McCombs, 1998) These interventions focus on the creation of a positive context for learning at all levels (classroom, school, district), and focus on creating and supporting a positive context for learning at all systems levels. Many students will state that what they like best about school are the teachers and others who *care* about them. In their review of successful dropout prevention programs, Peck, Law, and Mills (1989) discovered that the common denominator for success was the quality of the relationships established between adults and youths and a genuine caring for the students. Caring environments have been defined as those in which youngsters feel welcomed, respected, and comfortable, and where experiences were structured to provide an opportunity for students to develop caring relationships with adults and peers (Chaskin & Rauner, 1995).

As one adolescent girl, who had been in multiple foster home and group home placements, stated:

> School was the one place where I could feel normal and accepted. I could focus on schoolwork and I was good at it. I swam for the school swim team and played water polo, and I could pretend that I was just as normal as the rest. Thank God for my homeroom teacher. He treated me with respect and really cared about my success in school and life. I learned from him that not all men are going to abuse me.

As stated previously, many maltreated children behave in ways that serve to "reenact" the abuse with others, including teachers (Gil, 1996; James, 1994). Teachers who are normally quite caring may find themselves experiencing unwanted and unfamiliar feelings of anger and dislike for some of these children. Consultation that focuses on educating the teacher about the effects of maltreatment and modifying the child's negative internal working model, while at the same time promoting positive interactions between the child and teacher, may be especially helpful (Pianta, 1999).

Conclusion

Child maltreatment is a complex and multifaceted phenomenon, which can have devastating effects. The effects and impact of maltreatment ultimately interact with other factors such as the child's age, family support, and attachment-related experiences (Howe, 1998), and, as mental health professionals we must consider these factors when designing interventions. The school-based mental health professional is in a critical position to provide effective interventions for these youngsters, but we must also be realistic about what can and cannot be accomplished, and we must be farsighted and patient with our goals. Generally speaking, the earlier we intervene the better, and the less severe the case the better the outcome (Pianta, 1999). For those children who have been severely traumatized over a period of many years, we must take a wider and longer view of the child's journey through the school system, and we must look to design educational systems that promote success and combat risk over time. This effort requires not only direct intervention to ameliorate emotional suffering, but also indirect intervention such as curriculum development, parent and teacher consultation, the design of programs that promote prosocial behavior, and the promotion of caring communities in the schools. Without these indirect and preventative efforts, we are doomed to continually bear witness to the cycle of abuse.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, 48, 45-48.

Bowlby, J. (1969/1982). *Attachment and loss*. (Volume 1). New York: Basic Books. (Original work published 1969.)

Bowlby, J. (1988). *A secure base: Clinical implications of attachment theory*. London: Routledge & Kegan Paul.

Brock, S. E. (2002). Crisis theory: A foundation for the comprehensive crisis prevention and intervention team. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (pp. 5-17). Bethesda, MD: National Association of School Psychologists.

Carlson, E. A. (1998). A prospective, longitudinal study of disorganized/disoriented attachment. *Child Development*, 69, 1107-1128.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology*, 25, 525-531.

Chaskin, R. J., & Rauner, D. M. (1995). Youth and caring: An introduction. *Phi Delta Kappan*, 76, 667-674.

Cicchetti, D. (1991). Fractures in the crystal: Developmental psychopathology and the emergence of self. *Developmental Review*, 11, 271-287.

Conte, J., Wolf, S., & Smith T. (1989). What sexual offenders tell us about prevention: Preliminary findings. *Child Abuse and Neglect*, 13, 293-301.

Crittenden, P. M. (1985). Maltreated infants: Vulnerability and resilience. *Journal of Child Psychology and Psychiatry*, 26, 85-96.

Crittenden, P. M. (1989). Teaching maltreated children in the preschool. *Topics in Early Childhood Special Education*, 9, 16-32.

Crittenden, P. M., & Ainsworth, M. D. S. (1989). Attachment and child abuse. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 432-463). New York: Cambridge University Press.

Daro, D. (1991). Child sexual abuse and prevention: Separating fact from fiction. *Child Abuse and Neglect*, 15, 1-4.

Egeland, B., & Sroufe, L. A. (1981). Attachment and early maltreatment. *Child Development*, 52, 44-52.

Egeland, B., Jacobvitz, D., & Papatola, K. (1987). Intergenerational continuity of parental abuse. In J. Lancaster & R. Gelles (Eds.), *Biosocial aspects of child abuse* (pp. 255-278). San Francisco: Jossey-Bass.

Fahlberg, V. (1991). *A child's journey through placement*. Indianapolis, IN: Perspectives Press.

Fletcher, K. E. (1996). Childhood posttraumatic stress disorder. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (pp. 242-276). New York: Guilford Press.

Gil, E. (1996). *The healing power of play: Working with abused children*. New York: Guilford Press.

Greenberg, M. T., DeKlyen, M., Speltz, M. L., & Endriga, M. C. (1997). The role of attachment processes in externalizing psychopathology in young children. In L. Atkinson & K. J. Zucker (Eds.), *Attachment and Psychopathology* (pp. 196-222). New York: Guilford Press.

Howe, D. (1998). *Patterns of adoption*. Oxford, London: Blackwell.

Hubbs-Tait, L., Osofsky, J., Hann, D., & Culp, A. (1994). Predicting behavior problems and social competence in children of adolescent mothers. *Family Relations*, 43, 439-446.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in childhood*. New York: Lexington Books.

Jacobsen, T., Edelstein, W., & Hofman, V. (1994). A longitudinal study of the relation between representations of attachment in childhood and cognitive functioning in childhood and adolescence. *Developmental Psychology*, 30, 112-124.

Kaufman, J., & Zeigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry*, 57, 186-192.

Kazdin, A. E., Moser, J., Colbus, D., & Bell, R. (1985). Depressive symptoms among physically abused and psychiatrically disturbed children. *Journal of Abnormal Psychology*, 94, 298-307.

Lambert, N. M. & McCombs, B. L. (1998). Introduction: Learner-centered schools and classrooms as a direction for school reform. In N. M. Lambert & B. L. McCombs (Eds.), *How Students Learn* (pp. 1-22). Washington, DC: American Psychological Association.

LaFreniere, P. J., & Sroufe, A. (1985). Profiles of peer competence in the preschool: Interrelations between measures, influence of social ecology, and relation to attachment history. *Developmental Psychology*, 21, 56-66.

Lieberman, A. F., & Zeanah, C. H. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. R. Shavers (Eds.), *Handbook of attachment* (pp. 555-574). New York: Guilford Press.

Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behavior problems: The role of disorganized early attachment patterns. *Journal of Consulting and Clinical Psychology*, 64, 64-73.

Lyons-Ruth, K., Connell, D. B., Grunebaum, H., & Botein, S. (1990). Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment. *Child Development*, 61, 85-98.

Lyons-Ruth, K., Repacholi, B., McLeod, S., & Silva, E. (1991). Disorganized attachment behavior in infancy: Short-term stability, maternal and infant correlates, and risk-related subtypes. *Development and Psychopathology*, 3, 377-396.

Main, M. (1995). Recent studies in attachment: Overview with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: social, developmental, and clinical perspectives* (pp. 407-474). Hillsdale, NJ: Analytic Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development*, 50, 66-104.

Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a one-month period. *Developmental Psychology*, *24*, 1-12.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161-182). Chicago: University of Chicago Press.

McCombs, B. L. (1998). Integrating metacognition, affect, and motivation in improving teacher education. In N. M. Lambert & B. L. McCombs (Eds.), *How students learn* (pp. 379-408). Washington, DC: American Psychological Association.

McFarlane, A. C. (1990). Posttraumatic stress syndrome revisited. In H. J. Parad & L. G. Parad (Eds.), *Crisis intervention book 2: The practitioner's sourcebook for brief therapy* (pp. 69-92). Milwaukee, WI: Family Service America.

Oates, R. K. (1996). *The spectrum of child abuse*. New York: Brunner/Mazel.

O'Conner, M., Sigman, M., & Brill, N. (1987). Disorganization of attachment in relation to maternal alcohol consumption. *Journal of Clinical and Consulting Psychology*, 55, 831-836.

Ogawa, J. R., Sroufe, L. A., Weinfeld, N. S., Carlson, E. A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, 9, 855-879.

Pearce, J. W., & Pezzot-Pearce, T. D. (1997). *Psychotherapy of abused and neglected children*. New York: Guilford Press.

Peck, N., Law, A., & Mills, R.C. (1989). *Dropout prevention: What we have learned*. Ann Arbor, MI: ERIC Counseling and Personnel Services Clearinghouse.

Peters, K. D., Kochanek, K. D., & Murphy, S. L. (1998). *Deaths: Final data, 1996. National vital statistics report*, 47, Hyattsville, MD: National Center for Health Statistics [DHHS publication No. (PHS) 99-1120].

Pianta, R. C. (1999). *Enhancing relationships between children and teachers*. Washington, DC: American Psychological Association.

Plough, A. (1985). *Maltreatment and mother-toddler interaction*. Unpublished doctoral dissertation, University of Virginia.

Solomon, J., George, C., & DeJong, A. (1995). Children classified as controlling at age six: Evidence of disorganized representational strategies and aggression at home and at school. *Development and Psychopathology*, 7, 447-463.

Sroufe, L. A. (1990). Pathways to adaptation and maladaptation: Psychopathology as developmental deviation. In D. Cicchetti (Ed.), Rochester Symposium on *Developmental Psychopathology: Vol. 1. The emergence of a discipline* (pp. 13-40). Hillsdale, NJ: Erlbaum.

Sroufe, L. A. (1997). Psychopathology as an outcome of development. *Development and Psychopathology*, 9, 251-268.

Terr, L. C. (1983). Play therapy and psychic trauma: A preliminary report. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 308-319). New York: Wiley.

Terr, L. C. (1989). Treating psychic trauma in children: A preliminary discussion. *Journal of Traumatic Stress*, *2*, 3-20.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, *148*, 10-20.

Toth, S. L., Manly, J. T., & Cicchetti, D. (1992). Child maltreatment and vulnerability to depression. *Development and Psychopathology*, *4*, 97-112.

Tower, C.C. (1984). *Child abuse and neglect: National Educational Association multimedia training program*. Washington, DC: National Educational Association.

Tower, C.C. (1999). *Understanding Child Abuse and Neglect*. Needham Heights, MA: Allyn & Bacon.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. (1997). *Child maltreatment in 1995: Reports from the states to the National Child Abuse and Neglect Data System*. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information.

Van Ijzendoorn, M., & Bakersman-Kranenburg, M. (1996). Attachment representations in mothers, fathers, adolescents and clinical groups: A meta-analytic search· for normative data. *Journal of Consulting and Clinical Psychology*, *64*, 8-21.

Wartner, U.G., Grossman, K., Fremmer-Bombik, E., & Suess, G. (1994). Attachment patterns at age six in south Germany: Predictability from infancy and implications for preschool behavior. *Child Development*, *65*, 1014-1027.

Webb, N. B. (1999). *Play therapy with children in crisis*. New York: Guilford Press.

Wolfe, D. A., Sandler, J., & Kaufman, K. (1981). A competency-based parent training program for child abusers. *Journal of Consulting & Clinical Psychology*, *49*, 633-640.

Ysseldyke, J., Dawson, P., Lehr, C., Reschly, D., Reynolds, C., & Telzrow, C. (1997). *School psychology: A blueprint for training and practice II*. Bethesda, MD: National Association of School Psychologists.

Endnote

[1] Since the school-based mental health professional does not have the responsibility to investigate the *veracity* of the child's statement (but must report it regardless), techniques of investigation will not be addressed.

Appendix

Child Maltreatment Resources

American Humane Association (AHA)
Children's Division
63 Inverness Dr., East
Englewood, CO 80112-5117
Phone: (800) 227-4645 or (303) 792-9900
Fax: (303) 792-5333
E-mail: *children@americanhumane.org*
www.americanhumane.org

AHA's Children's Division convenes national forums to address issues in child welfare; designs and facilitates training for child welfare agencies; and publishes resources to help professionals, agencies, and communities meet the needs of children and families. Conducts research analysis and training to help public and private agencies respond to child maltreatment.

American Professional Society on the Abuse of Children (APSAC)
407 South Dearborn St., Suite 1300
Chicago, IL 60605
Phone: (312) 554-0166
Fax: (312) 554-0919
www.apsac.org

Provides professional education, promotes research to inform effective practice, and addresses public policy issues. Professional membership organization.

AVANCE Family Support and Education Program
301 South Frio, Suite 380
San Antonio, TX 78207
Phone: (210) 270-4630
Fax: (210) 270-4612
www.avance.org

Operates a national training center to share and disseminate information, material, and curricula to service providers and policymakers interested in supporting high-risk Hispanic families.

Boys and Girls Clubs of America
Office of Government Relations
600 Jefferson Plaza, Suite 401
Rockville, MD 20852
Phone: (301) 251-6676
Fax: (301) 294-3052
www.bgca.org

Offers local programs promoting health, social, educational, vocational, and character development to disadvantaged youths ages 6 to 18.

Center for the Prevention of Sexual and Domestic Violence (CPSDV)
936 N. 34th St., Suite 200
Seattle, WA 98103
Phone: (206) 634-1903
Fax: (206) 634-0115
E-mail: *cpsdv@cpsdv.org*
www.cpsdv.org

Interreligious educational resource addressing issues of sexual and domestic violence. The goal of the Center is to engage religious leaders in the task of ending abuse and to serve as a bridge between the religious and secular communities.

Childabuse.com
www.childabuse.com

Created to support, inform, and encourage those dealing with any aspect of child abuse in a positive, nonthreatening environment.

Childhelp USA
15757 N. 78th St.
Scottsdale, AZ 85260
National Child Abuse Hotline:
1-800-4-A-CHILD
(800) 2-A-CHILD (TDD line)
Phone: (480) 922-8212
E-mail: *help@childhelpusa.org*
www.childhelpusa.org

A nonprofit organization focused on meeting the needs of abused and neglected children through treatment, prevention, and research. Provides crisis counseling to adult survivors and child victims of child abuse, offenders, and parents. Operates national hotline.

Child Abuse Prevention Network
Cornell University
MVR Hall
Ithaca, NY 1453-4401
Phone: (607) 255-3888
Fax: (607) 255-8562
E-mail: tph3@cornell.edu
child.cornell.edu

Provides resources to professionals to support the identification, treatment, adjudication, and prevention of child abuse and neglect.

Child Trends
4301 Connecticut Ave., NW, Suite 100
Washington, DC 20008
Phone: (202) 362-5580
Fax: (202) 362-5533
E-mail: *amoore@childtrend.org*
www.childtrends.org

Conducts research, data collection, and data analysis on topics related to children, youths, and families, including welfare and poverty, children's health, fatherhood, family strengths, and youth development.

Child Welfare League of America (CWLA)
440 First St., NW, Third Floor
Washington, DC 20001
Phone: (202) 638-2952
Fax: (202) 638-4004
www.cwla.org

Provides training, consultation, and technical assistance to child welfare professionals and agencies while also educating the public about emerging issues affecting children.

Children's Defense Fund (CDF)
25 E St., NW
Washington, DC 20001
Phone: (202) 628-8787
Fax: (202) 662-3540
E-mail: *cdfinfo@childrensdefense.org*
www.childrensdefense.org

Provides technical assistance to state and local child advocates, gathers and disseminates data on children, and advocates for children's issues.

Children's Institute International (CII)
711 S. New Hampshire Ave.
Los Angeles, CA 90005
Phone: (213) 385-5100
Fax: (213) 393-1820
E-mail: *kclayton@childrensinstitute.org*
www.childrensinstitute.org

CII has developed a comprehensive multiservice prevention and treatment program for at-risk families. The program is implemented nationally and internationally.

Appendix continued p. 524

Appendix continued

Committee for Children (CFC)
2203 Airport Way South, Suite 500
Seattle, WA 98134-2027
Phone: (800) 634-4449 or (206) 343-1223
Fax: (206) 343-1445
www.cfchildren.org

Promotes the safety, well-being, and social development of children. CFC develops and publishes research-based curricula to encourage social and emotional literacy and to prevent youth violence and child abuse.

Family Life Development Center
Cornell University
Martha Van Rensselaer Hall
Ithaca, NY 14853-4401
Phone: (607) 255-7794
Fax: (607) 255-8562
child.cornell.edu

The Center's mission is to improve professional and public efforts to understand and deal with risk factors that lead to family violence and neglect. Current areas of special interest include childhood violence prevention; holistic community development; evaluation of programs designed to prevent child abuse and neglect; and acquiring, preserving, and disseminating high-quality data relevant to the study of child maltreatment.

Family Research Laboratory (FRL)
University of New Hampshire
126 Horton Social Science Center
Durham, NH 03824-3586
Phone: (603) 862-2761
Fax: (603) 862-1122
E-mail: *mas2@christa.unh.edu*
www.unh.edu/frl

Provides information on all aspects of family violence and abuse for professionals and researchers.

Family Support America (formerly Family Resource Coalition of America)
20 N. Wacker Dr., Suite 1100
Chicago, IL 60606
Phone: (312) 338-0900
Fax: (312) 338-1522
E-mail: *frca@frca.org*
www.frca.org

Works to strengthen and empower families and communities so that they can foster the optimal development of children, youths, and adult family members.

Family Violence and Sexual Assault Institute (FVSAI)
6160 Cornerstone Ct., East
San Diego, CA 92121
Phone: (858) 623-2777 ext. 406
Fax: (858) 646-0761
E-mail: *fvsai@cspp.edu*
www.fvsai.org

Provides information, networking, training education, and program evaluation for other agencies, practitioners, and organizations in the area of family violence.

International Society for Prevention of Child Abuse and Neglect (ISPCAN)
200 N. Michigan Ave., Suite 500
Chicago, IL 60601
Phone: (312) 578-1401
Fax: (630) 221-1313
E-mail: *ISPCAN@aol.com*
ispcan.org

ISPCAN was established to connect a worldwide cross-section of committed professionals and organizations that protect children from abuse and neglect.

Kempe Children's Center
1825 Marion St.
Denver, CO 80218
Phone: (303) 864-5252
Fax: (303) 864-5302
E-mail: *Kempe@KempeCenter.org*
kempecenter.org

A clinically based resource providing training, consultation, program development and evaluation, and research in child abuse and neglect. The Center is committed to multidisciplinary approaches to the prevention, identification, and treatment of all forms of abuse and neglect.

MELD: Programs to Strengthen Families
123 N. 3rd St., Suite 507
Minneapolis, MN 55401
Phone: (612) 332-7563
Fax: (612) 344-1959
E-mail: *meldctrl@aol.com*
meld.org

Provides training, materials, and replicable programs related to parent support. MELD's materials and programs are designed to meet the cultural and linguistic needs of parents who participate, including Hispanic/Latino parents, Hmong parents, and teen parents.

National Alliance of Children's Trust and Prevention Funds (ACT)
Michigan State University
Department of Psychology
East Lansing, MI 48824-1117
Phone: (517) 432-5096
Fax: (517) 432-2476
E-mail: *millsda@pilot.msu.edu*
www.msu.edu/user/millsda/index.html

The mission of the National Alliance is to build and maintain a system of services, laws, practices, and attitudes that prevent child abuse and neglect. The Alliance assists Children's Trust and Prevention Funds at the state and national levels to strengthen families and protect children from harm.

National Center for Education in Maternal and Child Health (NCEMCH)
2000 15th St., North, Suite 701
Arlington, VA 22201-2617
Phone: (703) 524-7802
Fax: (703) 524-9335
E-mail: *info@ncemch.org*
www.ncemch.org

Provides national leadership to the maternal and child health community in the areas of program development, policy analysis, education, and state-of-the-art knowledge to improve the health and well-being of the nation's children and families.

National Children's Advocacy Center (NCAC)
200 Westside Sq., Suite 700
Huntsville AL 35801
Phone: (256) 533-0531
Fax: (256) 534-6883
E-mail: *webmaster@ncac-hsv.org*
www.ncac-hsv.org

Provides prevention, intervention, and treatment services to physically and sexually abused children and their families within a child-focused team approach.

National Children's Alliance
1319 F St., NW, Suite 1001
Washington, DC 20004-1106
Phone: (202) 639-0597 or (800) 239-9950
Fax: (202) 639-0511
E-mail: *info@nncac.org*
www.nca-online.org

A nonprofit membership organization whose mission is to provide training, technical assistance, and networking opportunities to communities seeking to plan, establish, and improve Children's Advocacy Centers. These Centers further the goal of serving abused children through a comprehensive approach to services for victims and their families. Assists communities in planning, establishing, and improving Children's Advocacy Centers.

Appendix continued p. 526

Appendix continued

National Clearinghouse for Child Abuse and Neglect (NCCAN)
330 C Street, SW
Washington, DC 20447
Phone: (800) 394-3366 or (703) 385-7565
Fax: (703) 385-3206
E-mail: *nccanch@calib.com*
www.calib.com/nccanch

A national resource for professionals seeking information on the prevention, identification, and treatment of child abuse and neglect and related child welfare issues.

National Council on Child Abuse and Family Violence
1155 Connecticut Ave., NW, Suite 400
Washington, DC 20036
Phone: (202) 429-6695
Fax: (202) 655-3930
E-mail: NCCAFV@*aol.com*
www.nccafv.org

Provides information on family violence for victims and professionals.

National Court Appointed Special Advocate Association
100 West Harrison St., North Tower
Suite 500
Seattle, WA 98119
Phone: (206) 270-0072 or (800) 628-3233
Fax: (206) 270-0078
E-mail: *staff@nationalcasa.org*
www.nationalcasa.org
www.casanet.org (for professionals)

Provides training, legal research, fundraising, public awareness, and government relations services to local, court-appointed special advocates and child welfare professionals.

National Crime Prevention Council (NCPC)
1700 K St., NW, Second Floor
Washington, DC 20006
Phone: (202) 466-6272
Fax: (202) 296-1356
www.ncpc.org

A private, nonprofit organization that provides information on family violence for victims and professionals.

National Data Archive on Child Abuse and Neglect
Cornell University
Family Life Development Center
Ithaca, NY 14853-4401
Phone: (607) 255-7799
Fax: (607) 2558562
E-mail: *DataCAN@cornell.edu*
www.ndacan.cornell.edu

Facilitates secondary analysis of research data relevant to the study of child abuse and neglect. The Archive maintains numerous databases, including the National Child Abuse and Neglect Data System (NCANDS) and Adoption and Foster Care Analysis Reporting System (AFCARS).

National Education Association
1201 16th Street, NW
Washington, DC 20036
Phone: (202) 833-4000
Fax: (202) 822-7377
www.nea.org

America's oldest and largest organization committed to advancing the cause of public education. NEA proudly claims more than 2.3 million members who work at every level of education, from preschool to university graduate programs.

National Exchange Club Foundation for the Prevention of Child Abuse
3050 Central Ave.
Toledo, OH 43606-1700
Phone: (800) 924-2643 or (419) 535-3232
Fax: (419) 535-1989
E-mail: *info@preventchildabuse.com*
www.preventchildabuse.com

Develops, promotes, and implements programs that seek to eliminate child abuse and strengthen families. The Foundation coordinates a nationwide network of Exchange Club Child Abuse Prevention Centers that provide support to families at risk for abuse. Provides education, intervention, and support to families affected by child maltreatment. Produces prevention materials.

National Indian Child Welfare Association (NICWA)
3611 SW Hood St., Suite 201
Portland, OR 97201
Phone: (503) 222-4044
Fax: (503) 222-4007
E-mail: *info@nicwa.org* or *justkim@nicwa.org*
URL: *www.nicwa.org*

NICWA has served hundreds of American Indian tribes throughout the United States by helping to strengthen and enhance their capacity to deliver quality child welfare services. NICWA's major activities are community development, public policy development, and information exchange. Disseminates information and provides technical assistance on Indian child welfare issues. Supports community development and advocacy efforts to facilitate tribal responses to the needs of families and children.

National Maternal and Child Health Clearinghouse (NMCHC)
2070 Chain Bridge Rd., Suite 450
Vienna, VA 22182-2536
Phone: (888) 434-4NMCH or
(703) 356-1964
Fax: (703) 821-2098
E-mail: *nmchc@circsol.com*
www.nmchc.org

Distributes publications and other resources on a range of maternal and child health topics. An integral part of the Clearinghouse, the National Sudden Infant Death Syndrome (SIDS) Resource Center, distributes materials to professionals, parents, and the general public.

National Network for Youth
1319 F St., NW, Suite 401
Washington, DC 20004
Phone: (202) 783-7949
Fax: (202) 783-7955
E-mail: *NN4youth@worldnet.att.net*
www.nn4youth.org

Promotes the delivery of high-quality services among youth-serving agencies. Provides written materials and responds to general inquiries regarding runaways and adolescent abuse, and serves as a referral source for runaways and parents.

National Organization for Victim Assistance
1757 Park Rd., NW
Washington, DC 20010
Phone: (800) TRY-NOVA or (202) 232-6682
Fax: (202) 462-2255
E-mail: *nova@try-nova.org*
www.try-nova.org

Assists children and adult victims of family violence with a 24-hour hotline and short-term counseling, maintains an information clearinghouse, and provides training and technical assistance to state and local programs.

Appendix continued p. 528

Appendix continued

National Resource Center for Community-Based Resource and Support Programs (FRIENDS)
Chapel Hill Training Outreach Project
800 Eastowne Dr., Suite 105
Chapel Hill, NC 27514
Phone: (800) 888-7970
Fax: (919) 968-8879
www.frca.org/friends.htm

Provides training and technical assistance to lead agencies implementing the Community-Based Family Resource and Support (CBFRS) grant program in the following key areas: parent leadership training, family resource and support programs and service, services to diverse populations, establishment of respite care programs, and creation of funding strategies. Requests for FRIENDS services are initiated by CBFRS state lead agencies.

National Resource Center on Child Maltreatment
Child Welfare Institute
3950 Shackleford Road, Suite 175
Duluth, GA 30096
Phone: (770) 935-8484
Fax: (770) 935-0344
E-mail: *NRCCM@gocwi.org*
gocwi.org/nrccm

Helps states, local agencies, and tribes develop effective and efficient child protective services (CPS) systems. Jointly operated by the Child Welfare Institute and ACTION for Child Protection, the Center responds to needs related to prevention, identification, intervention, and treatment of child abuse and neglect.

National Society for the Prevention of Cruelty to Children (NSPCC)
National Centre
42 Curtain Road
London
EC2A 3NH
United Kingdom
Phone: 020 7825 2500
Fax: 020 7825 2525
www.nspcc.org.uk/

Specializes in child protection and the prevention of cruelty to children. Provides links to resource materials and volunteer opportunities.

Office for Victims of Crime Resource Center
Box 600
Rockville, MD 20849-6000
Phone: (800) 627-6872
Fax: (301) 519-5212
E-mail: *askncjrs@ncjrs.org*
www.ncjrs.org

Provides information on family violence for professionals and researchers.

PANdora's Box
The Secrecy of Child Sexual Abuse
www.prevent-abuse-now.com/

Contains more than 270 pages of child protection and abuse prevention information.

Parents Anonymous, Inc.
675 W. Foothill Blvd., Suite 220
Claremont, CA 91711
Phone: (909) 621-6184
Fax: (909) 625-6304
E-mail: *parentsanon@msn.com*
www.parentsanonymous-natl.org

Parents Anonymous encourages all parents to ask for help early to effectively break the cycle of abuse. To ensure accessibility to all community members, Parents Anonymous groups meet in local community centers, churches, schools, housing projects, shelters, and prisons. Parents Anonymous also operates local 24-hour hotlines to provide an immediate response to parents seeking help. Leads mutual support groups for parents. Helps parents to provide nurturing environments for their families.

Prevent Child Abuse America
200 S. Michigan Ave., 17th Floor
Chicago, IL 60604
Phone: (800) 835-2671 (orders) or
(312) 663-3520
Fax: (312) 939-8962
E-mail: *mailbox@preventchildabuse.org*
www.preventchildabuse.org

Promotes healthy parenting and community involvement as effective strategies for preventing all forms of child abuse. The organization's nationwide network of chapters and local affiliates work to implement direct service programs in hundreds of communities. Conducts prevention activities such as public awareness campaigns, advocacy, networking, research, and publishing. Provides information and statistics on child abuse and maintains an extensive publications list.

Safer Society Foundation, Inc.
P.O. Box 340
Brandon, VT 05733-0340
Phone: (802) 247-3132
Fax: (802) 247-4233
www.safersociety.org

A research, advocacy, and referral center on the prevention and treatment of sexual abuse. The Foundation's services include training and consultation; a comprehensive resource library; and print, audio, and video resources for professionals and the general public available through the Safer Press.

Shaken Baby Syndrome Prevention Plus (SBS Prevention Plus)
649 Main St., Suite B
Groveport, OH 43125
Phone: (800) 858-5222
Fax: (614) 836-8359
E-mail: *sbspp@aol.com*
www.sbsplus.com

The mission of SBS Prevention Plus is to develop, study, and disseminate information and materials designed to prevent shaken baby syndrome and other forms of physical child abuse and to increase positive parenting and child care.

Society for Prevention Research (SPR)
St. Francis Medical Center
10 E. 45th St.
Pittsburgh, PA 15201
Phone: (412) 688-3502
www.oslc.org/spr/sprhome.html

A professional organization concerned with problems, issues, and challenges related to the prevention of public health and social problems such as drug, alcohol, and tobacco use and abuse; mental health problems; delinquency, crime, and violence; and child abuse.

Appendix continued p. 530

Appendix continued

Zero to Three: National Center for Infants, Toddlers and Families
734 15th St., NW, Suite 1000
Washington, DC 20005-1013
Phone: (800) 899-4301 or (202) 638-1144
Fax: (202) 638-0851
E-mail: *0to3@zerotothree.org*
www.zerotothree.org

The mission of Zero to Three is to advance the healthy development of babies and young children, especially early brain development. Zero to Three provides publications and other resources to parents and professionals, including child care providers and clinicians.

26

Suicide Intervention

危
機

Richard Lieberman, M.A.
Los Angeles Unified School District

John M. Davis, Ph.D.
California State University, Hayward
Raskob Learning Institute, Holy Names College

It is dismissal time, and a 17-year-old student is attempting to give away her 3-month-old child. She has approached the school resource officer (SRO) and asked his assistance in getting the baby to the child's godmother. She states that she wants the child's godmother to care for her baby after she is gone. The SRO recognizes that this student is giving away her most prized possession and calmly asks her to accompany him to the nurse's office, where she will be able to call the child's godmother. At this point, the school psychologist is summoned and the principal alerted. The psychologist collaborates with the principal, nurse, and SRO, and assesses this student as being at risk for suicidal behavior. This student has a history of prior suicidal behavior and episodes of depression. In addition, a search of her purse has revealed two bottles of Tylenol. Three hours pass as the school attempts to contact the father and the aunt (the only two emergency names in the student's file). During this time the student has grown increasingly agitated. The student has had to be restrained in handcuffs by two local police officers, who were called to assist school staff after efforts to reach the father and aunt proved futile. Soon after the police arrive, the student's father arrives. Embarrassed by his daughter's screams, he clearly wants to take her home. The police instruct the psychologist to release the student to the father. After collaborating with team members, the principal informs the police that school staff has assessed the student as being at high risk for suicidal behavior and that they have decided not to release the student to the father if he simply intends to take her home. While the police confer, school staff uses this opportunity to try to convince the father that his daughter needs an emergency mental health evaluation. However, the father reiterates his intention to "just take her home." At this point the principal informs the father that if he insists on taking his daughter home, school policy requires the principal to alert child protective services. With this information, seeing how irrational his daughter has become, and knowing of her prior suicide attempts, the father is now convinced of the need for mental health assistance. When the police return, the father informs them that he wants his daughter to be escorted to the local mental health facility.

Every day in America, school personnel respond to situations like the one described above. Although such situations require an immediate response, it is important to acknowledge that students do not become suicidal suddenly and without warning. They get there after traveling down a long road (a continuum) of self-destructive behavior. Where educators intercept the child on this road determines their responsibilities. From the outset of the referral, school mental health professionals must project confidence, competence, and authority while maintaining a calm and empathetic manner. Youths must feel connected with the caregiver, at a most vulnerable time, to trust that the staff member will advocate for their well-being.

As was illustrated in the situation described above, suicide intervention is complicated. This chapter provides information that will assist in this process. It begins with a discussion of the issues that make suicide intervention unique. This is followed by an exploration of developmental and cultural issues. Finally, and perhaps most importantly, the chapter concludes with a detailed exploration of suicide intervention.

Unique Crisis Issues

Suicide intervention is a special form of crisis intervention, and suicide intervenors must be prepared to address several unique issues, including the fact that the stakes are especially high during a suicide intervention. This form of crisis intervention is quite literally a life and death matter. Consequently, crisis intervenor stress is especially high during a suicide intervention. When combined with the stigma and taboo surrounding suicide, it is not surprising that many caregivers are reluctant to provide suicide intervention services. Obviously, this fact is most unfortunate because the crisis of attempted or completed suicide is preventable. Such prevention requires not only a willingness to accept a heavy responsibility, but also knowledge of suicide warning signs and risk factors. Thus, this section explores the unique warning signs and risk factors associated with suicidal ideation and behaviors. This section also explores some of the legal issues associated with suicide intervention.

Warning Signs of Youth Suicide

Individuals who are thinking about suicide usually give signals (Ramsay, Tanney, Tierney & Lang, 1996). It has been widely reported that four out of five suicide victims display warning signs, often providing verbal clues (Hyde & Forsyth, 1978). Elementary age children do not typically self-refer, and it is often their behaviors that provide the clues to their intentions. Thus, knowledge of warning signs is a suicide intervention prerequisite. Effective school suicide intervention plans need to ensure that students, parents, and school personnel are knowledgeable of warning signs and instructed on how to refer the individual for appropriate assessment. Some common warning signs of youth suicide are summarized below.

Suicide threats. Threats may be direct (e.g., "I want to die," or "I am going to kill myself") or, unfortunately, indirect (e.g., "The world would be better without me," "Nobody will miss me anyway"). In adolescence, indirect clues can be offered through joking or through references in school assignments, particularly creative writing, or artwork. In concrete and preoperational children, indirect clues may come in the form of acting-out or violent behavior often accompanied by suicidal/homicidal threats (Davis & Brock, 2002).

Suicide plan, method, and means. Suicidal thoughts must be distinguished from actual behaviors (Beebe, 1975). The greater the planning, the greater the risk (Ramsay et al., 1996). In evaluating the suicidal potential of a student, the lethality and availability of the means and the level of sophistication of the plan (including the developmental level of the interviewee) must be taken into account (Davis & Brock, 2002). Familiar methods for younger children include running into traffic; jumping from high places; and cutting, scratching, or marking their body.

Previous attempts. Adolescents with a history of prior suicide attempts are at increased risk for a variety of negative outcomes, including repeat attempts; psychiatric symptoms; and academic, social, and behavioral problems (Shaffer & Piacentini, 1994). Fifteen percent of individuals with a history of one or more suicide attempts will go on to kill themselves (Maris, 1992). It is estimated that 26 to 33% of adolescent suicide victims have made a previous attempt [American Foundation for Suicide Prevention (AFSP), 1996].

Making final arrangements. In adolescents, this behavior might include giving away prized possessions (e.g., jewelry, clothing, a journal, or even a child). It seems likely that preoperational elementary children lack the cognitive skills necessary to make final arrangements, so this warning sign is typically not observed.

Symptoms of depression. When symptoms of depression include pervasive thoughts of helplessness and hopelessness, a child or adolescent is at greater risk for suicide (Beck, 1986; Glantz, Haas, & Sweeney, 1995).

Risk Factors of Youth Suicide

Youth suicides are multidimensional and complex behaviors with many associated risk factors, including psychopathological disorders, familial factors, biological factors, environmental factors, and situational crises (Berman & Jobes, 1991; Davis & Brock, 2002; Moscicki, 1995).

Psychopathological disorders. There is strong evidence that more than 90% of children and adolescents who commit suicide have experienced a mental or emotional disorder before their death (Conwell et al., 1996; Shaffer et al., 1996). The disorders most closely associated with suicide are affective disorder and substance abuse (Brent & Perper, 1995). Intoxication is present in half of all youth suicide (Moscicki, 1995). Individuals with a history of alcohol abuse are six times more likely to die by suicide than the general population (Ramsay et al., 1996).

The most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder (U.S. Department of Health and Human Services, 1999). Estimates are that 60% of suicide victims are diagnosed with depression. Thus, in the scenario described at the beginning of the chapter, the student's history of depression added to the concern. There is substantial comorbidity of depression with conduct problems and drug or alcohol abuse among high school students reporting suicide attempts. Comorbidity increases the risk of a suicide attempt beyond that found among adolescents who report these disorders in isolation from one another (Wagner, Cole, & Swartzman, 1996).

Familial factors. Family characteristics that increase youth suicide risk include a family history of suicide and of medical and/or psychiatric illness. Economic stress, significant family strife, and family loss are also associated with increased risk, and suicidal children experience more parental separations, divorces, and remarriages (Davis & Brock, 2002; Davis & Sandoval, 1991). Suicidal adolescents perceive their families as being less cohesive and more disengaged. Conflict and violence occur at increased rates within these families (King et al., 1995).

Biological factors. Although biological risk factors are not at present particularly useful in identifying suicide risk, it is important to acknowledge that neuro-chemical studies provide evidence of serotonergic dysfunction in adult suicide attempters and completers (Moscicki, 1995). Perhaps at some point in the future, such factors may prove helpful to school suicide prevention and intervention.

Environmental factors. Perhaps the strongest situational risk factor, at least in the United States, is the presence of a firearm (Brent et al., 1991; Kellerman et al., 1992). Use of a firearm is the most common method of suicide among male and female, younger and older adolescents and for all races (Karchur, Potter, James, & Powell, 1995). Many believe that the increased rate of youth suicide over the past four decades is largely related to the use of firearms as a method [American Association of Suicidology (AAS), 1996]. Guns in the home, particularly loaded guns, are associated with increased risk for suicide by youths, both with and without identifiable mental health problems or suicidal risk factors (Brent et al., 1993). Although many gun owners reportedly keep a firearm in their home for "protection or self defense," 83% of gun-related deaths in these homes are the result of a suicide, often by someone other than the gun owner. In general, states with stricter gun laws have lower rates of suicide (AFSP, 1996).

Situational crises. As high as 40% of youth suicidal behaviors appear to have identifiable antecedents (Davis & Brock, 2002). It is useful to consider suicide as comprising two related factors. The first, an acute situational crisis, is a precipitating event, an event of emotional relevance to a particular adolescent. When this co-occurs in a youth with a second factor, such as chronically poor coping skills, risk is greatly increased (AAS, 1996).

The types of crises, or stressors, most often associated with suicidal behavior are those that result in some type of loss. In particular, loss that is judged as significantly devaluing one's life is associated with suicide (Ramsay et al., 1996). The most common situational crisis precipitating adolescent suicide attempts are interpersonal crises. In this situation, the intent of the behavior appears to be to effect change in the behaviors or attitudes of others (AAS, 1996). Oftentimes, in the aftermath of a suicide, these situational factors may be mistakenly viewed as a cause of suicide. It is only when combined with other risk factors, such as those just discussed, however, that situational crises create the conditions that lead to suicide (Moscicki, 1995). Examples of other situational crises that *may* precipitate youth suicide include death (especially traumatic death) of a significant other, parental divorce, family moves, incarceration, trouble at school, family violence, parental arguments, physical and sexual abuse, running away from home, and exposure to suicidality in others (AAS, 1996; Brock & Sandoval, 1996; Davis & Brock, 2002; Davis & Sandoval, 1991; Moscicki, 1995; Ramsey et al., 1996).

Legal Issues in Suicide Intervention

Landmark cases, such as Kelson v. The City of Springfield (1985), have helped to define the responsibilities of schools and their employees when confronted with a suicidal student. School districts have been found liable for not offering suicide prevention programs, providing inadequate supervision of a suicidal student, and failing to notify parents when their children were suicidal (Wyke v. Polk County School Board, 1997). The liability issues are foreseeability and negligence. That is, if a child writes or talks about suicide, adults (particularly trained adults such as school psychologists or counselors) should be able to foresee a potential suicide. It is negligent on the part of the school not to notify parents or guardians when students are known to be suicidal. It is also negligent not to supervise the student closely (Poland & McCormick, 1999). Even when a student denies suicidal intent, if the collaborative team suspects the child to be suicidal, they have an obligation to notify parents (Eisel v. Board of Education of Montgomery County, 1991).

Although school district personnel should intervene whenever a child threatens suicide or manifests signs of the intent to commit suicide, most courts have recognized that schools are not equipped to do the necessary in-depth counseling and treatment of children. Rather, the courts hold that school personnel are in a position to make referrals and have a duty to secure assistance from others, with parental involvement, when a child is at risk (Davis & Sandoval, 1991).

Districts have a responsibility to provide adequate staff training in suicide prevention. Litigation against the schools has also occurred on the rare occasion of a suicide completion after a student was disciplined (suspended or expelled). Situational crises as precipitating events have already been discussed in this chapter. School mental health professionals can play a significant role in providing adequate training for all school staff and collaborating with administrators when students are involved in serious discipline procedures.

Developmental Factors

In 1997, people under age 25 (Hoyert, Konanek, & Murphy, 1999) committed 14% of all suicides. Suicide rates for those 15 to 19 years old are 300% higher than those same age peers of the 1950s, but have remained largely stable at these higher levels since 1980. Alarmingly, the suicide rates for those between the ages of 10 to 14, however, have increased 196% in the last 15 years (AAS, 1996; Peters, Konchanek, & Murphy, 1998).

Research shows that mortality from suicide, which increases steadily through the teen years, is the third leading cause of death for youths between the ages of 15 to 24 and fourth for those aged 10 to 14 (Hoyert et al., 1999). Among 15 to 19 year olds, for every female suicide there are 4.4 male suicides. Among 20 to 24 year olds, this ratio increases to 6.8:1. Conversely, among 10 to 14 year olds this ratio is the smallest: 2.7 male suicides for every female suicide (AAS, 1996). It has been estimated that there are more than 100 youth suicide attempts for every youth suicide (Ramsay et al., 1996) and, in the 15- to 19-year-old age group, girls make two of every three of these attempts (U.S. Department of Health and Human Services, 1999).

Especially when dealing with younger students at risk for suicide, it is important to be aware of a cognitive developmental perspective. Normand and Mishara (1992) suggested that youth understanding of the concept of suicide is clearly related to their age as well as their concept of and experiences with death. A more recent paper suggested that all school children have some general knowledge about suicide (Mishara, 1999). While studies of the progression of children's understanding of suicide are rare, there is a more substantial body of literature on the development of ideas about death. Piagetian theory states that, in the formal operational period, death is seen as not only irreversible, but also as personal. However, Orbach and Glaubman (1979) caution:

> … many children show a split in the death concept: they may have a mature concept of impersonal death, but a rather childish concept of their own personal death. Only the exploration of the emotional and personal aspects of the death concept is of value diagnostically and therapeutically. (p. 677)

In the assessment of suicide risk, school mental health professionals are cautioned that, when students are thinking about hurting themselves, it is best to assume they are not thinking logically. It would not be unusual for any student, sometimes even as old as 16, to view death as magical, temporary, and reversible. This situation is illustrated in the following scenario:

> An eighth-grade girl comes into the school psychologist's office on Friday as school lets out. When the psychologist says, "I'll see you on Monday," the student responds, "No you won't." After identifying that

the student is thinking of suicide, the psychologist conducts a suicide risk assessment. During the assessment phase the psychologist inquires why the student wants to die. She angrily responds: "to hover over my coffin and watch my mother cry!" The psychologist responds: "I do not know much about death, but I do know there is no hovering. You will not ever know if your mother cried because you will be dead. Now I am going to get some help for you today, and when you are feeling better we will begin working together on some better ways to cope with your anger toward your mom."

Ethnicity, Cultural Factors, and Sexual Orientation

The suicide rate for white males (15 to 24) has tripled since 1950, and the rate for white females (15 to 24) has doubled. Although data regarding suicidal behavior among minority youths are very limited (Roberts, Chen & Roberts, 1997), recent CDC studies have identified at risk populations previously unrecognized. Between 1980 and 1992 the suicide rate for African American males (10 to 14) increased 300% while the rate for white females (10 to 14) increased almost 240% (Karchur et al., 1995).

Overall, African American male adolescents (15 to 24) have shown the greatest increase in suicide completion rates in the 1990s relative to other races and ethnicities (AAS, 1996). Their rate has risen by 67% over the past 15 years (AFSP, 1996). Risk factors for African American suicide include being male, substance abuse, psychiatric disorder, antisocial behavior, and homosexuality. Protective factors that mitigate the risks of suicide include religious affiliation and social support (Gibbs, 1997).

Recent data suggest that, in 1997, Mexican American students had the highest rates of suicidal ideation and behaviors (Kann et al., 1998) and were more likely than other students to attempt suicide (U.S. Department of Health and Human Services, 1999). However, this has yet to translate into a substantial increase in completed suicides. Heightened levels of acculturative stress may result in critical levels of suicidal ideation in Mexican American adolescents (Hovey & King, 1996).

The Native American male adolescent and young adult are still the highest risk group in the United States. The rate in Indian Health Service areas was the highest in the nation at 62.0 per 100,000 (Wallace, Calhoun, Powell, O'Neil, & James, 1996). The problem of acculturation has been proposed as one of the major causes of depression and suicidal behavior among Native Americans. The majority of research, however, reports that Native American individuals who attempt or complete suicide mention precipitating causes such as grief over loss and quarrels with relatives and friends (Lester, 1997).

Gay and lesbian youths are 200 to 300% more likely to attempt suicide than other young people, and they may account for up to 30% of completed youth suicide annually (Gibson, 1989). Recent analyses of the Youth Risk Behavior Survey, compiled by the state of Massachusetts (1997), revealed that adolescents who identified themselves as gay, lesbian, or bisexual reported significantly higher rates of considering suicide than their heterosexual peers (54% vs. 22%); making a suicide plan (41% vs. 18%); actually attempting suicide (37% vs. 8%); and of requiring medical attention for a suicide attempt (19% vs. 3%).

We share Moscicki's (1995) observation that, in general, research on this issue is complicated by the lack of accurate information on the true rate of homosexuality in the population and the strong emotions it generates in many otherwise objective discussions. When gay and lesbian students are referred, practitioners assessing suicide risk are advised that this may be a population, similar to the Native American youths, with higher rates of victimization, drug and alcohol abuse, and familial rejection.

Today's school mental health professional faces a population of referred youths that are growing in racial and cultural diversity. Language and cultural differences increasingly complicate the already complex referral process, as illustrated in the following scenario:

> Nazia lived with her mother and appeared to be a typical Pakistani-American teenager. She had friends from diverse cultures and on weekends enjoyed attending parties and rap concerts. Recently, her mother became quite anxious about what might become of her 14-year-old daughter if something tragic should happen to the mother. The mother was a Pakistani-in-America. She only spoke in her native language, only dressed in traditional clothes, and possessed only Pakistani friends. To resolve her dilemma, the mother chose to arrange a marriage for her daughter. One night, a local, wealthy 21-year-old university student showed up at Nazia's door ready to exchange vows. After a highly emotional outburst, Nazia consented. The next day, at school, while being consoled by her friend in the school bathroom, Nazia attempted suicide by swallowing a bottle of Tylenol. Her friends brought her to the school nurse who immediately called the paramedics.

Practitioners will need to familiarize themselves with the many cultures represented in their school districts and strengthen their skills with cultural awareness. School psychologists will also need to use interpreters when necessary and to become aware of appropriate community agencies that focus on the needs of specific populations.

Crisis Intervention

Poland (1989) has indicated that school suicide intervention responsibilities include: (a) detecting suicidal students, (b) assessing suicide threat severity, (c) notifying parents, (d) attaining needed mental health services, (e) supervising the suicidal student, and (f) providing follow-up at school. We now explore these and other general suicide intervention strategies.

Collaborate. School mental health professionals dealing with suicidal youth should seek support and collaboration from their colleagues (Poland, 1989, 1995). The intervention process is fraught with unexpected developments. Having the support and consultation from an administrator and one other staff member (perhaps the school nurse, counselor, or social worker) is both reassuring and prudent because difficult decisions are often necessary when advocating for a suicidal youth.

Assign a "designated reporter." Schools should identify one or more individuals to receive and act upon all reports from teachers and other staff about students who may be suicidal (Davis & Sandoval, 1991). This individual is frequently a school psychologist or counselor.

Supervise the student. School psychologists and counselors should inform all students they counsel of the following: "There are three pieces of information that, if you tell me, I must tell someone else in order to help you. These are (a) if you are being abused, endangered, or neglected in any way, anywhere; (b) if you are planning to harm yourself; or if (c) you are planning to hurt another." In many cases, when students confess their suicidal intentions, they are unaware that the school psychologist, or any educator for that matter, is not bound by confidentiality and is obligated to report their comments or actions to their parents (or protective services, to be discussed later). It is always best to inform the student what you are going to do every step of the way. Solicit the student's assistance when appropriate. Under no circumstances should the student be allowed to leave school or be alone (even in the restroom). Reassure and supervise the student until a parent can assume responsibility. It may be appropriate to solicit the aid of collaborators to monitor the student while the psychologist or counselor seeks a phone in private.

Mobilize a support system. The school must establish a support system that will carry the youth through the difficult challenges ahead long after the student leaves the school. Assessment of that support system will also contribute to evaluating the student's risk. It is often sensible to just ask the student: "Who do you want and who do you think will be there for you now?" and assist the student in achieving that support. It is important for the student to feel some control over his or her fate.

Implement no-suicide contracts. In our experience, "no-suicide" contracts are effective in helping to prevent youth suicide. Examples can be found in Poland (1989, 1995) and Davis and Sandoval (1991). This type of contract helps students take control over their suicidal impulses and reduces the anxiety of both students and the school mental health professional (Berman & Jobes, 1991; Davis & Sandoval, 1991). In cases where the suicide risk is judged low enough not to require an immediate treatment (e.g., there is only ideation and no suicide plan), a no-suicide contract is still recommended to provide the student with alternatives should his or her suicide risk level increase in the future. Such a contract is a personal agreement to postpone suicidal behaviors until help can be obtained. Poland (1989) suggested "each contract be tailor made for the student. The most official looking school stationery should be used. The contract should be signed by the student and the counselor and the student should be given a copy" (p.82). However, contracts should not be used in isolation (Barrett, 1985). The contract can also serve as an effective assessment tool. If students refuse to sign, they cannot guarantee they will not hurt themselves. The risk assessment immediately becomes high risk, and the student must be constantly supervised until a parent can assume responsibility.

Suicide-proof the environment. Whether or not a child is in imminent danger, it is recommended that both the home and school be suicide-proofed (Davis & Sandoval, 1991). Before the child returns home and thereafter, all guns, poisons, medications, and sharp objects must be removed or made inaccessible.

Call police. All school crisis teams should have a representative from local law enforcement. If a student resists, becomes combative, or attempts to flee, law enforcement can be of invaluable assistance. In some cases they can assume responsibility for securing a "72-hour hold," which will place the youth in protective custody up to three days for psychiatric observation.

Document. Every school district should develop a documentation form for support personnel and crisis team members to record their actions in responding to a suicidal student. A sample documentation form is provided in Figure 1. Information should include reasons for referral and actions taken.

A Suicide Intervention Model

The intervention component of the Los Angeles Unified School District's (LAUSD) Youth Suicide Prevention Program mandates four steps. First, the intervenor must assess the student's risk for suicidal behavior. Such data will determine the course of action. Second, the intervenor has a duty to warn. This will involve notifying the student's parent or a protective service agency. Third, the intervenor has a duty to refer the students to the appropriate community resources. Typically, these will be professional mental health services. Finally, the intervenor must provide follow-up and support the family in accessing community resources. We now discuss each of these four components of the LAUSD's suicide intervention protocol.

1. Conduct a suicide risk assessment. Davis and Brock (2002) identify nine areas of questioning that the suicide risk assessment interview needs to address. These areas include suicide potential, suicide plan, past suicide attempts, affects and behaviors, family background, precipitating events, response from the support network, concept of death, and ego functions.

Figure 1

This form can be used to document the actions of school personnel when responding to a suicidal student.

Risk Assessment Referral Data

Referral Date: ________________ Time: ________
MO/DAY/YR

1. Student's Name: ________________ LAST ________________ FIRST ________ MI

2. School: ________ LOC CODE ________________ SCHOOL NAME Cluster: ________

3. Grade: ________________

4. Birthdate: ________________ MO/DAY/YR 5. Age: ________ 6. Sex: ___ M ___ F

7. Ethnicity: ________________

8. Lives With: ___ A. Both Parents ___ B. Mother ___ C. Father ___ D. Other Guardian

9. Parent/Guardian Name: ________________ LAST ________________ FIRST ________ MI

10. Address: ________ NUMBER ________________ STREET ________ APT. NO.

City: ________________ Zip: ________

11. Phone: Home (___) ________________ Work (___) ________________

12. Current Educational Program:
___ A. Regular
___ B. Gifted
___ C. Resource Specialist
___ D. Special Day Class
___ E. Other (Specify)
___ F. Magnet

13. Bilingual Status: ___ A. LEP ___ B. FEP ___ C. English Only

14. Student Referred by: (CHECK ONE OR MORE)
___ A. Self
___ B. Parent
___ C. Teacher
___ D. Counselor
___ E. Psychologist
___ F. SAAS Counselor
___ G. Nurses
___ H. Other (Specify) ________
___ I. Student/Friend

15. Reason for Referral: (CHECK ONE OR MORE)
___ A. Direct Threat
___ B. Indirect Threat
___ C. Previous Attempt(s) Indicated
___ D. Giving Away Prized Possessions
___ E. Mood Swings
___ F. Sudden Changes in Behavior
___ G. Signs of Depression
___ H. Truancy or Running Away
___ I. Frequent Complaints of Illness or Bodily Aches
___ J. Drug or Alcohol Abuse
___ K. Other (Specify) ________
___ L. Current Attempt
___ M. Completion: Date ________
___ N. Update of Current RARD
Date of Update: ________

16. Previous Risk Assessment Referral: ___ No ___ Yes

17. Data Recorded by (Case Carrier):
___ A. Counselor
___ B. Psychologist
___ C. Nurse
___ D. SAAS Counselor
___ E. Administrator
___ F. Other (Specify) ________

18. Intervention(s)/Outcome(s): (CHECK WHERE APPROPRIATE. SEE # 18 UNDER DIRECTIONS)
___ A. Parent Contact Made
___ B. Parental Brochure Provided
___ C. Referral to Community Agency
___ D. Child Abuse Form Filed (ENDANGERMENT)
___ E. Hospitalization
___ F. Other (Specify) ________
G. School Support Strategies
___ 1. Group Counseling
___ 2. Individual Counseling
___ 3. Peer Counseling
___ 4. Program Modification
___ 5. Other (Specify) ________

19. School Transfer (Specify School): ________________ Date: ________

Figure 1 continued on p. 542

Figure 1 continued

Directions for Completing the Risk Assessment and Referral Data (RARD)

To be completed by counselor/site team member:

- All items are to be printed.
- **Referral Date/Time:** Indicate date/time referral is received by counselor/site team member.

Item Numbers: (INDICATE THE FOLLOWING:)

1. Student's last name, first name, and middle initial.
2. School's location code and name.
3. Student's current grade.
4. Student's date of birth.
5. Student's age in years.
6. Student's sex: place a checkmark next to "M" for male or "F" for female.
7. Write in student's ethnicity.
8. Person(s) with whom student lives: place a checkmark next to the appropriate person(s).
9. Parent/guardian last name and first name.
10. Parent/guardian complete address, including number, street, apartment number (if applicable), city, and zip code.
11. Parent/guardian home and work phone numbers. (Include area code.)
12. Student's current educational program: place a checkmark next to the word that best describes student's program. If the student's current educational program is not listed, indicate program by writing it next to the word "Other."
13. Student's bilingual status: place a checkmark next to the appropriate acronym or word that describes the student's status.
14. Person(s) who referred the student to the counselor/site team member: place one or more checkmarks next to the appropriate person(s).
15. The reason(s) student was referred to counselor/site team member: place a checkmark next to the appropriate reason(s). (A student can be referred for reasons other than for suicide warning sign. Suicidal behavior can emerge during an intake interview.)
16. Whether student has had a RARD form completed prior to current referral: place a checkmark next to the word "Yes" or "No."
17. The position of the person completing the RARD form: place a checkmark next to appropriate title.
18. The intervention(s)/outcome(s) that occurred with respect to this student's referral: place one or more checkmarks next to the appropriate outcomes. **NOTE:** Every referral requires A. Parent contact made and B. Parent Brochure provided and C. Referral to Community Agency, unless there are extenuating circumstances.
19. Student's school transfer: specify name of new school and date of transfer.

The experience of talking to a suicidal child can be extremely stressful for the designated reporter. Poland (1989) recommends the use of a Risk Assessment worksheet. Brock and Sandoval (1996) offer sample questions for interviewing the suicidal student (Table 1).

School psychologists and counselors, however, are often asked to make critical risk assessments under extraordinary time constraints. Thus, it is important for a risk assessment protocol to have a specific set of questions that will quickly and reliably obtain needed information (Ramsay et al., 1996). Questions often used as part of the LAUSD risk assessment protocol address the following:

- What warning sign(s) initiated the referral?
- Has the student thought about suicide (thoughts or threats alone, whether direct or indirect, may indicate low risk)?
- Have they tried to hurt themselves before (previous attempts may indicate moderate risk)?
- Do they have a plan to harm themselves now?
- What method are they planning to use, and do they have access to the means (these questions would indicate high risk)?
- What is the student's support system (including parents in the risk assessment is critical to determining the adequacy of the support system)?

Assessment instruments that may assist the school psychologist or counselor fall into two categories: those that measure suicide potential, and those that measure risk factors. Lists of these instruments, their uses, and their relative merits can be found in Davis and Brock (2002), Range and Knott (1997), and Davis and Sandoval (1991).

2. *Notify parents.* There is no question that parents must be notified (Poland, 1989). In addressing this aspect of suicide intervention, four critical questions need to be addressed: (1) Are parents available? (2) Are parents cooperative? (3) What information do parents have that might contribute to the assessment of risk? (4) What mental health insurance, if any, does the family possess? *If the parent is available and cooperative and the student is judged high risk,* the psychologist or counselor must provide them with community referral resources specific to where the family resides and based on health insurance status. With parental permission, the school psychologist or counselor should contact the agency, provide pertinent referral information, and follow up to ensure the family's arrival at the agency. If necessary, the school mental health professional should assist the parent in transporting the student to the agency. The psychologist should obtain a parent's signature on a release of information form and assist school staff in working with parents to develop a school support plan. All actions must be documented.

Table 1

Brock and Sandoval's (1996) Student Interview Model for Suicide Risk Screening

---

Engagement

- It seems things haven't been going so well for you lately. Your parents and/or teachers have said ____________________. Most teens/children would find that upsetting.
- Have you felt upset, maybe some sad or angry feelings you've had trouble talking about? Maybe I could help you talk about these feelings and thoughts?
- Do you feel like things can get better, or are you worried (afraid, concerned) things will just stay the same or get worse?
- Are you feeling unhappy most of the time?

Identification

- Other teenagers/children I've talked to have said that when they feel that sad and/or angry, they thought for a while that things would be better if they were dead. Have you ever thought that? What were your thoughts?
- Is the feeling of unhappiness so strong that sometimes you wish you were dead?
- Do you sometimes feel that you want to take your own life?
- How often have you had these thoughts? How long do they stay with you?
- Administer the Suicidal Ideation Questionnaire (Reynolds, 1988) or the Hopelessness Scale for Children (Kazdin et. al., 1986) to further qualify and/or quantify the seriousness of the student's suicidal thinking.

Inquiry

- What has made you feel so awful?
- What problems/situations have led you to think this way?
- Tell me more about what has led you to see killing yourself as a solution.
- What do you think it would feel like to be dead?
- How do you think your father and mother feel? What do you think would happen with them if you were dead?
- As appropriate, administer items from the Mental Status Exam (Davis & Sandoval, 1991).

Assessment

Current Suicide Plan

- Have you thought about how you might make yourself die?
- Do you have a plan?
- On a scale of 1 to 10, how likely is it that you will kill yourself? When are you planning to or when do you think you will do this?
- Do you have the means with you now, at school, or at home?
- Where are you planning to kill yourself?
- Have you written a note?
- Have you put things in order?

Prior Behavior

- Has any one that you know of killed or attempted to kill themselves? Do you know why?
- Have you ever threatened to kill yourself before? When? What stopped you?
- Have you ever tried to kill yourself before? How did you attempt to do so?

Resources

- Is there anyone or anything that would stop you?
- Is there someone whom you can talk to about these feelings?
- Have you or can you talk to your family or friends about suicide?

Summary

- Use a suicide risk assessment worksheet (e.g., Poland, 1989) to summarize the information gained during the interview(s).

Note
From Brock, S. E., & Sandoval, J. (1996). Suicidal ideation and behaviors. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems, and alternatives* (pp. 361-374). Bethesda, MD: National Association of School Psychologists.

If the parents are unavailable and the student is judged high risk, then, at the discretion of the school site administrator, two members of the crisis team should escort the child to the nearest emergency mental health facility. They will also need to coordinate with the agency's social services department on continuing to attempt to contact a parent. Alternatively, school law enforcement, local police, or a mobile psychiatric response team may be asked to assist in transporting the suicidal youth.

Some parents are reluctant to follow through on crisis team recommendations to secure outside counseling for the suicidal youth. Cultural and language issues are frequent contributors to this reluctance. It is recommended that parents be given appropriate opportunity and encouragement to follow through before collaborating with crisis team members on when to proceed to the next step. The school crisis team must decide when it is appropriate to report a parent to child protective services if their reluctance is truly negligence and endangers the life of the child. If it is determined that parents *are uncooperative and the student is judged to be at high risk* for suicidal behavior, then the school should contact local law enforcement or child protective services and fill out a child neglect and endangerment report. If *the parents are uncooperative and the student is judged at low risk* for suicidal behavior, then it is recommended that the school obtain a parental signature on a "Notification of Emergency Conference" form (Poland, 1995). This form (provided in Figure 2) can document that the parents were notified of their child's suicidal assessment in a timely fashion.

There will be occasions *when a student does not want the parents notified*. When children are thinking of harming themselves, they are not thinking clearly and, therefore, may not be the best judge of their parent's response. The crisis team has only one decision to make: Will the child be placed in a more dangerous situation by notifying the parents? In such a situation, child protective services is typically notified. The parents must still be notified, and it is the challenge of school personnel to elicit a supportive response from parents. School personnel have been found liable in court for failing to notify parents when their child was suicidal (Poland, 1995; Poland & McCormick, 1999).

Parents often have critical information necessary to make an appropriate assessment of risk. Thus, it is critical to *include parents in the risk assessment*. This information may include previous school and mental health history, family dynamics, recent traumatic events in the student's life, and previous suicidal behaviors. Interviewing parents will also assist the psychologist and/or counselor in making an appropriate assessment of the support system that surrounds this student.

Finally, it is important to determine what mental health insurance the family has. This information is essential in directing families to appropriate community agencies. All modern mental health intake interviews include questions regarding insurance coverage, and it is wise for school psychologists and counselors to be aware of various local providers. If a student is directed to an emergency clinic, they may later require emergency transport to an appropriate HMO provider. This may not only further trauma-

Figure 2

This sample form can be used to verify that parents have been informed of their child's suicidal ideation.

I/We ____________________, the parents of ____________________ were involved in a conference with school personnel on ____________. We have been notified that our child is suicidal. We have been further advised that we should seek some psychological/psychiatric consultation immediately from the community. School personnel have clarified the district's role and will provide follow-up assistance to our child to support the treatment services from the community.

____________________ ____________________
Parent or Legal Guardian School Staff Member, Title

Note
From Poland, S. (1995). Best practices in suicide intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 155-166). Washington, DC: National Association of School Psychologists.

---

tize a suicidal student (because most transports must be done under restraints), but also generate a significant bill for the family. It is certainly in the best interest of the student and family to limit the trauma of any student in need of emergency action.

3. ***Provide referrals.*** It is critical to identify and collaborate with community agencies before the crisis occurs. It is recommended that the school crisis team representative call the agency to provide accurate information that parents may omit. School districts have an obligation to suggest agencies that are nonproprietary or offer sliding scale fees.

4. ***Follow up and support the student and his or her family.*** Finally, it is important for school staff to provide ongoing modifications and support, perhaps utilizing student study teams. Such support might include: (a) referral for psycho-educational assessment, (b) individualizing classroom assignments, (c) assigning a peer tutor, (d) reducing academic demands, (e) participating in conflict or anger management programs, (f) participating in extracurricular activities, and (g) directing the family to appropriate community agencies.

Concluding Remarks

Research has revealed that youth suicide transcends all boundaries such as gender, age, ethnicity, geographical location, or socioeconomic status. This chapter discussed the risk factors and warning signs of youth suicide and provided the school mental health professional with general intervention strategies and a school intervention model.

As schools continue to be confronted with referrals of depressed and suicidal students, the role of the school mental health professional in providing leadership has never been so critical. These professionals face the following challenges:

- Promote primary prevention programs, such as substance/alcohol abuse, violence, dropout, and pregnancy programs, which address at-risk youths.
- Assist schools in linking with parents, community law enforcement, and mental health agencies.
- Advocate for school site crisis teams to implement and collaborate on appropriate intervention and postvention strategies.
- Provide staff development on youth suicide risk factors, warning signs, and referral processes.
- Advocate for the mental health needs of students who return to school following expulsion, mental health hospitalization, or other traumatic events.
- Support programs to reduce accessibility to firearms.

No school or community should have to suffer the devastation, confusion, uncertainty, and shock that occur in the aftermath of a suicide. Gandhi once said: "Be the difference that you want in the world." School mental health professionals can be such a difference in suicide prevention.

References

American Association of Suicidology. (1996, November 15). *Youth suicide by firearms task force*. Available Online: www.suicidology.org/youthsuicidetaskforce.htm

American Foundation for Suicide Prevention. (1996). *Fact sheet*. Available Online: www.afsp.org

Barrett, T. (1985). *Youth in crisis: Seeking solutions to self-destructive behavior*. Longmont, CO: Sopris West.

Beck, A. T. (1986). Hopelessness as a predictor of eventual suicide. *Journal of the Annals of the New York Academy of Science*, *487*, 90-96.

Beebe, J. E. (1975). Evaluation of the suicidal patient. In C. P. Rosenbaum & J. E. Beebe, (Eds.), *Psychiatric treatment: Crisis, clinic and consultation*. New York: Basic Books.

Berman, A. L., & Jobes, D. A. (1991). *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association.

Brent, D. A., & Perper, J. A. (1995). Research in adolescent suicide: Implications for training, service delivery and public policy. *Suicide & Life-Threatening Behavior*, *25*, 222-230.

Brent, D. A., Perper, J. A., Allman, C. J., Moritz, G. M., Wartella, M. E., & Zelenak, J. P. (1991). The presence and accessibility of firearms in the home of adolescent suicides: A case-control study. *Journal of the American Medical Association*, *266*, 2989-2995.

Brent, D. A., Perper, J. A., Moritz, G., Gaugher, M., Schweers, J., & Roth, C. (1993). Firearms and adolescent suicides: A case-control study. *American Journal of Diseases of Children*, *147*, 1066-1071.

Brock, S. E., & Sandoval, J. (1996). Suicidal ideation and behaviors. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp.361-374). Bethesda, MD: National Association of School Psychologists.

Centers for Disease Control. Suicide among black youths, United States, 1980-1995. (1998, March 20). *Morbidity and Mortality Weekly Report*, *47*, 193-196.

Conwell, Y., Duberstein, P.R., Cox, C., Hermann, J.H., Forbes, N.T., & Caine, E.D. (1996). Relationships of age and Axis I diagnoses in victims of completed suicide: A psychological autopsy study. *American Journal of Psychiatry*, *153*, 1001-1008.

Davis, J. M. & Brock, S. E. (2002). Suicide. In J. Sandoval (Ed.), *Handbook of crisis counseling, intervention and prevention in the schools* (2nd ed., pp. 273-299). Hillsdale, NJ: Earlbaum.

Davis, J. M., & Sandoval, J. (1991). *Suicidal youth: School-based intervention and prevention*. San Francisco: Jossey-Bass.

Eisel v. Board of Education of Montgomery County, 597 A.2nd 447 Maryland, 1991.

Gibbs, J. T. (1997). African-American suicide: A cultural paradox. *Suicide & Life-Threatening Behavior*, *27*, 68-79.

Gibson, P. (1989). Gay male and lesbian youth suicide. *U.S. Department of Health and Human Services: Report of the Secretary's Task Force on Youth Suicide* (Vol. 3, pp. 115-

142). Washington, DC: Government Printing Office.

Glantz, L. M., Hass, G. L., & Sweeney, J. A. (1995). Assessment of hopelessness in suicidal patients. *Clinical Psychology Review, 15*, 49-64.

Hovey, J. D., & King, C. A. (1996). Acculturative stress, depression and suicidal ideation among immigrant and second generation Latino adolescents. *Journal of American Academy of Child & Adolescent Psychiatry, 35*, 1183-1192.

Hoyert, D. L., Konanek, K. D., & Murphy, S. L. (1999). Deaths: Final data for 1997. *National Vital Statistics Report, 47*, [DHHS Publication No. (PHS) 99-1120.] Hyattsville, MD: National Center for Health Statistics.

Hyde, M., & Forsyth, E. (1978). *Suicide*. New York: Franklin Watts.

Kann, L., Kinchen, S. A., Williams, B. I., Ross, J. G., Lowry, R., Hill, C. V., Grunbaum, J., Blumson, D. S., Collins, J. L., & Kolbe, J. L. (1998). Youth risk surveillance-United States, 1997. *Morbidity and Mortality Weekly Report, 47*, 1-89.

Karchur, S. P., Potter, L. B., James, S. P., & Powell, K. E. (1995). *Suicide in the United States 1980-1992*. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Violence Surveillance Summary Series, No. 1.

Kazdin, A. E., Rodgers, A., & Colbus, D. (1986). The Hopelessness Scale for Children: Psychometric characteristics and concurrent validity. *Journal of Consulting and Clinical Psychology, 54*, 241-245.

Kellerman, A. L., Rivara, F. P., Somes, G., Reay, D. T., Francisco, J., Banton, J. G., Prodzinski, J., Flinger, C., & Hackman, B. B. (1992). Suicide in the home in relationship to gun ownership. *New England Journal of Medicine, 327*, 467-472.

Kelson v. The City of Springfield, 767 F2nd 651 (1985).

King C. A., Segal, H., Kaminiski, K., Naylor, M., Ghaziuddin, N., & Rodpour, L. (1995). A prospective study of adolescent suicidal behavior following hospitalization. *Suicide & Life-Threatening Behavior, 25*, 327-338.

Lester, D. (1997). Suicide in America: A nation of immigrants. *Suicide and Life-Threatening Behavior, 27*, 50-59.

Maris, R. W. (1992). How are suicides different? In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 65-87). New York: Guilford Press.

Massachusetts Department of Education. (1997). *1997 Massachusetts Youth Risk Behavior Survey Results*. Boston: Author.

Mishara, B. L. (1999). Concepts of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide & Life-Threatening Behavior, 29*, 105-118.

Moscicki, E. K. (1995). Epidemiology of suicidal behavior. *Suicide & Life-Threatening Behavior, 25*, 22-35.

Normand, C. L., & Mishara, B. L. (1992). The development of the concept of suicide in children. *Omega: Journal of Death and Dying, 25*, 183-203.

Orbach, I., & Glaubman, H. (1979). The concept of death and suicidal behavior in young children. *Journal of the American Academy of Child Psychiatry, 18*, 668-678.

Peters, K. D., Konchanek, K. D. & Murphy, S. L. (1998). *Deaths: Final data, 1996 National vital statistics report, 47*, [DHHS Publication No. (PHS) 99-1120.]

Hyattsville, MD: National Center for Health Statistics.

Poland, S. (1989). *Suicide intervention in the schools*. New York: Guilford Press.

Poland, S. (1995). Best practices in suicide intervention. In A. Thomas, & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 155-166). Washington, DC: National Association of School Psychologists.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Ramsay, R. F., Tanney, B. L., Tierney, R. J., & Lang, W. A. (1996). *Suicide intervention workshop* (6th ed.). Calgary, AB: LivingWorks.

Range, L. M., & Knott, E. C. (1997). Twenty suicide assessment instruments: Evaluation and recommendations. *Death Studies*, *21*, 25-58.

Reynolds, W. M. (1988). *The Suicidal Ideation Questionnaire: Professional manual*. Odessa, FL: Psychological Assessment Resources.

Roberts, R. E., Chen, Y. R., & Roberts, C. R. (1997). Ethnocultural differences in prevalence of adolescent suicidal behaviors. *Suicide & Life-Threatening Behavior*, *27*, 208-217.

Shaffer, D., Gould, M. S., Fisher, P., Trautment, P., Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, *53*, 339-348.

Shaffer, D., & Piacentini, J. (1994). Suicide and suicide attempts. In M. Rutter, L. Hersov, & E. Taylor (Eds.), *Child and adolescent psychiatry* (3rd ed., pp. 407-424). London: Blackwell Scientific.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Wagner, B. M., Cole, R. E., & Swartzman, P. (1996). Comorbidity of symptoms among junior and senior high school suicide attempters. *Suicide & Life-Threatening Behavior*, *26*, 300-307.

Wallace, J. D., Calhoun, A. D., Powell, K. E., O'Neil, J., & James, S. P. (1996). *Homicide and suicide among Native Americans, 1979-1992* (Violence Surveillance Series, No. 2). Atlanta: Centers for Disease Control.

Wyke v. Polk County School Board 11th Cir., 1997.

27

危
機

School Suicide Postvention

Stephen E. Brock, Ph.D.
California State University, Sacramento

James was a well-liked high school junior. Active in after school-sports, he was considered by many to be a "popular" student. Over the course of the past year, however, James had developed a serious alcohol problem. In fact, his drinking at weekend parties had become something of a local legend. Friday after school, James' girlfriend broke up with him claiming that she could no longer tolerate his drinking. Distraught, James went home, got drunk, found his father's rifle and shot himself in the head. Quickly discovered by a classmate, who had stopped by for a visit, James was rushed to the hospital. Tragically, he was declared dead upon arrival. In a suicide note, James declared that if he could not be with his girlfriend he did not want to live. By the start of school on the following Monday, this death had been classified as a suicide by the coroner's office. Reacting to the social stigma surrounding suicide and fearing other such deaths, the school principal suggested that staff not talk "too much" about this tragedy. The stunned staff, anxious about the topic of suicide in the first place, took this as a cue to try to deny the magnitude of this tragedy. Very little classroom discussion occurred.

According to the American Association of Suicidology (1998), "Postvention is the provision of crisis intervention, support and assistance for those affected by a completed suicide" (p. 1). "Affected" individuals may include classmates, friends, teachers, co-workers, and family members. These individuals are often referred to as "survivors" of suicide (Knieper, 1999). Because survivors are at increased risk for depression, posttraumatic stress, suicidal ideation, and exacerbation of preexisting conduct and substance abuse disorders (Brent et al., 1992; U.S. Department of Health and Human Services, 1999), an immediate postvention response is prudent. This chapter explores this special form of crisis intervention, with particular reference to its use in the school setting. It begins with a discussion of the unique issues addressed by postvention. Next, it explores developmental and cultural issues relevant to suicide postvention. The chapter concludes with a detailed discussion of a specific suicide postvention protocol.

Special Suicide Postvention Issues

The primary goal of the crisis intervention response is to help reestablish immediate coping. Because it is a form of crisis intervention, suicide postvention also aims to help individuals cope adaptively with psychological trauma. While postvention has much in common with general crisis intervention, it must address several specific issues, including suicide contagion, unique emotional reactions, and social stigma.

Contagion

One of the most frightening issues confronting those who respond to the crisis of a completed suicide is the potential for imitative behavior (or "suicide contagion"). Although this phenomenon is poorly understood, numerous documented cases of suicide clusters are thought to be due to contagion (Poland, 1989).[1] The potential for imitative suicidal behavior appears to be greatest among the adolescent population (Davidson, 1989). Phillips and Carstensen (1986), for example, report that adolescent suicide rates increased 6.9% in the 7 to 10 days following TV broadcasts of suicide stories. On the other hand, adult rates increased only 0.5%. Although death as part of a suicide cluster is a relatively rare occurrence (Moscicki, 1995; O'Carroll, Mercy, & Steward, 1988),[2] prevention of contagion is an important and unique goal of suicide postvention activities. In the situation described above, crisis response team members need to be sensitive to the possibility that other students may copy James' suicidal behavior. Important crisis intervention strategies for preventing contagion, unique to suicide postvention, include avoiding (a) sensationalizing the death, (b) glorifying or vilifying the suicide victim, and (c) providing excessive details about the suicidal act.

Avoid sensationalism. Crisis intervention following a suicide must strive to ensure that unnecessary attention is not given to this act. For example, following an event such as James' death, the school should provide postvention in normal/natural environments (e.g., classrooms) and avoid schoolwide activities (e.g., assemblies). In addition, the school should discourage permanent physical memorials recognizing James' death and request the media to downplay the incident.

Avoid glorification or vilification. Crisis intervention following a suicide must avoid glorifying or vilifying the suicide victim, either of which might facilitate identification with the victim. For example, following James' death, school administrators should ensure that the death is not romanticized. Students must not be allowed to view this as a noble act of unrequited love.

Do not provide excessive details. Crisis intervention following a suicide must not provide excessive detail about the suicidal act. Typically, following most other crisis events, it is important to give students as many details about the tragedy as they request. This knowledge can help students gain cognitive mastery over a crisis event. Furthermore, crisis facts are typically less frightening than crisis rumors. This general crisis intervention rule, however, does not apply following a suicide. To reduce the risk of imitative behavior following a suicide, it is recommended that excessive detail *not* be reported (Poland & McCormick, 1999). For example, in the scenario described at the beginning of this chapter, school personnel can announce that James' suicide was by a self-inflicted gunshot; however, they should not go into detail about the type of gun used, the location and extent of the wound, etc. In addition, the school should avoid releasing details such as the time or circumstances of the death (Garfinkel et al., 1988; Poland & McCormick, 1999). Finally, the contents of a suicide note should not be revealed. For example, besides placing a significant burden on the ex-girlfriend, the contents of James' note might facilitate identification and imitation of this act.

Emotional Reactions

As with any sudden and unexpected death, a suicide generates feelings of grief with which survivors may have difficulty coping. However, a suicide can result in particularly complicated and devastating grief (American Association of Suicidology, 1998; Jordan, 2001; Knieper, 1999). Especially among those closest to the suicide victims, feelings of anger, guilt, rejection, shame, and isolation are to be expected.

Those left behind by a suicide often believe they did something wrong or somehow failed the suicide victim (Jordan, 2001). These beliefs can lead to self-reproach, intense guilt, and shame. Associated with these emotions are feelings of social rejection and isolation (Knieper, 1999). The suicide postvention must be prepared to respond to these emotional reactions. For example, following James' suicide, special efforts must be made to help James' friends (especially his ex-girlfriend) cope with feelings that they are somehow responsible for the death. Postvention must ensure that these emotional reactions do not result in the social isolation of survivors.

Social Stigma

Suicide is a phenomenon surrounded by social stigma and avoidance (Knieper, 1999). Given this fact it is not surprising that "... there is considerable evidence that suicide survivors are viewed more negatively by others and by themselves" (Jordan, 2001, p. 94). Consequently, students and staff members may be uncomfortable talking about such a death. Those left behind by a suicide may receive (and/or perceive) much less social support for their loss than might the survivors of other causes of death (Roberts, Lepkowski, & Davidson, 1998). Especially when combined with the emotional reactions of self-blame and shame, the social stigma of suicide results in survivors feeling uncomfortable and awkward among traditional social support systems (e.g., family and friends). Thus, the suicide postvention must address this issue to ensure that those left behind receive necessary support (Knieper, 1999). Finally, as illustrated by the scenario at the beginning of this chapter, the stigma of suicide may translate into reluctance to provide postvention services (Poland, 1989).[3]

Developmental Issues

Understanding of Suicide

It appears that it is not until the fifth grade that students have a clear understanding of what the term "suicide" means and are aware that it is a psychosocial dynamic that leads to suicidal behavior. While primary-grade children appear to understand the concept of killing oneself, they typically do not recognize the term suicide and generally do not understand the dynamics that lead to this behavior (Mishara, 1999). Thus, the postvention for younger students will need to take into account their understanding of suicidal behavior. Such an intervention cannot assume that students understand what suicide means.

Severity of Grief

Callahan (2000) has reported a consensus in the bereavement literature that "older bereaved individuals have a less severe course of grief than younger ones" (p. 105). Research by Reed (1993) has suggested that this relationship between age and severity of grief is found among suicide survivors. From a sample ranging in age from 15 to 82 years, Reed interpreted his data as suggesting that, following a suicide, "older survivors are less grief stricken than their younger counter parts" (p. 213). From these data it might be argued that younger survivors are in need of greater support. However, it must be acknowledged that the relationship between grief and age following a suicide is poorly understood among the school-aged population.

Risk of Contagion

A final developmental issue of importance to suicide postvention is the fact that the risk of suicidal ideation and behaviors increases through the school years. Although estimates vary, it is generally agreed that child suicide is relatively rare (Diekstra & Garnefski, 1995; Moscicki, 1995). As youths enter adolescence, however, the risk of suicide increases. After the age of 10 suicide becomes a leading cause of death. Currently, suicide ranks as the fourth leading cause of death in the 10- to 14-year-old age group (exceeded by accidents, cancer, and homicide) and as the third leading cause of death among 15- to 24-year-olds (exceeded by accidents and homicide) (National Center for Injury Prevention and Control, 1998). When combined with the observation that the potential to imitate suicidal behavior appears to be a unique issue for teenagers (Davidson, 1989), these data mean that postvention for older students should include relatively greater concern regarding contagion. Conversely, contagion would not be as significant a concern when working with younger, elementary-grade children.

Cultural Issues

Arguably, the most important cultural issue regarding suicide postvention is the fact that attitudes toward such behavior vary considerably from culture to culture. While some cultures may view suicide as appropriate under certain circumstances, others have strong sanctions against all such behavior (Ramsay, Tanney, Tierney & Lang, 1996). The postvention needs to be sensitive to such differences. For example, the bereavement process will be significantly complicated among individuals who have deep religious beliefs and/or moral convictions that suicide is wrong. These individuals not only have to cope with the loss, but also have to deal with the sanctions imposed on them and/or the descendant by the given belief system. On the other hand, because of their beliefs/convictions, the risk for imitative suicidal behavior among such a group may be lessened. Conversely, when working with individuals who have attitudes that are more permissive toward suicide, the grieving process may not be as complicated by culturally imposed sanctions; however, they might be considered at greater risk for suicide contagion.

Crisis Intervention

A specific suicide postvention protocol is reviewed in the remaining pages of this chapter. Before beginning this discussion, however, two points need to be made. First, it is critical to acknowledge that preparedness is an essential component of effective postvention (American Association of Suicidology, 1998; Davidson, 1989; Gould & Kramer, 2001; Lamb & Dunne-Maxim, 1997; O'Carroll et al., 1988; Roberts et al., 1998; Thompson, 1995; Wenckstern & Leenaars, 1993). Suicide postvention procedures should be developed *before* a suicide occurs. Second, the crisis response team should make sure that a postvention is needed before initiating this type of crisis intervention. Unfortunately, suicide is a common occurrence in our society, with 30,000 Americans killing themselves each year (U.S. Public Health Service, 1999). Obviously, not all of these suicides have the same impact upon a given school. Thus, the first issue a crisis response team should address following a suicide is whether postvention is needed. Providing postvention when it is not needed runs the risk of sensationalizing this act.

The key question is whether problems generated by the suicide will present coping challenges. This question can typically be answered by examining who committed suicide and the circumstances of the death. If the decedent was well known (e.g., a popular student or a teacher) and/or the suicide was public (e.g., occurring at school), then a postvention will likely be needed. Simply put, if students are not likely to become aware of a given suicide, postvention should not be provided. According to Ruof and Harris (1988): "Suicidal behavior is only contagious if other people know about it. We agree that if you can keep knowledge of attempts out of a school building it is probably wise to do so" (p. 8). In other words, if a postvention is provided when it is not required it will bring undue attention to the suicide and may send the message that suicide is a way to be noticed. At the same time, however, it must be acknowledged that the worst-case scenario is for students to know of a suicide and to have school personnel pretend that it did not occur (as was the case following James' suicide). Further discussion of this issue is offered later in this chapter's discussion of assessment of the suicide's impact on the school.

The following suicide postvention protocol is designed to give schools a prioritized list of procedures to implement following a completed suicide. These are listed in order of importance on the basis of my experience. Ideally, however, different crisis response team members will work on several of these postvention tasks simultaneously. The timeline for the completion of this protocol will vary; however, the school should initiate it immediately upon learning of a death. The school should take steps toward the completion of all but the final three postvention procedures within 24 hours. A checklist summarizing this suicide postvention protocol is provided in the this chapter's Appendix.

Verify That a Death Has Occurred

Immediately after receiving reports that a death has occurred, an administrator (usually the school principal) should begin efforts to verify the facts (Wenckstern & Leenaars, 1993). If a suicide is suspected, then contact the coroner's office, which will officially classify the death. In addition to the coroner's office, other possible sources of information might include police or sheriff departments, hospitals, and the family of the suicide victim. It is critical that the school staff does not accept statements from students (or even teachers) that a suicide has occurred without first verifying the facts (Garfinkel et al., 1988; Poland & McCormick, 1999). The legal classification of a death as suicide is complex and typically made by medical examiners working within a coroner's office. Avoid labeling *any* death as suicide until an official determination is made. Serious problems result from telling students that a peer committed suicide, only to later have the cause of death be ruled an accident (or, even worse, to find out that the student has not even died).

Mobilize the Crisis Response Team

Once a death has been verified, the administrator should immediately mobilize the school's crisis response team (O'Carroll et al., 1988). Together, the team will complete all of the remaining postvention tasks. While successful suicide postvention requires a team effort, primary responsibility for specific postvention activities is usually assigned to specific team members filling specific roles. According to Brock, Sandoval, and Lewis (2001), these roles include a crisis response coordinator, crisis intervention coordinator, media liaison, medical liaison, and security liaison. Table 1 lists a brief description of the suicide postvention duties of these crisis response team members.

Table 1

Crisis Response Team Roles and Suicide Postvention Responsibilities

Crisis Response Coordinator (CRC). The CRC is typically a school principal or district-level administrator. This individual is responsible for verifying that a death has occurred (Berman & Jobes, 1991) and then mobilizing the crisis response team. The CRC initiates and oversees all postvention interventions and is the person to whom all reports of sudden, unexpected deaths should be given. It is appropriate to let emergency service personnel and the coroner's office know that this individual can be contacted day or night with news regarding any sudden death. This is important because having all the facts is essential to quelling rumors that may arise about the suicide (Garfinkel et al., 1988).

Crisis Intervention Coordinator (CIC). The CIC is typically a school-based mental health professional. This individual's primary responsibilities include identification of individuals in need of postvention assistance. The CIC plays a central role in planning and implementing interventions. As a part of some suicide postventions, it may be necessary for community mental health resources to be a part of the intervention. The CIC is responsible for obtaining such assistance.

Media Liaison. According to Davidson (1989): "Providing reasonable access to information, controlling rumors, and protecting students from intrusive news reporters are important concerns" (p. 96). From these observations, it is recommended that a school system identify a single spokesperson who will provide the press with a single and accurate account of the event (Berman & Jobes, 1991; Davidson, 1989; Davis & Sandoval, 1991; O'Carroll, Mercy, & Steward, 1988). The media liaison fills this role. He or she is typically a school or district-level administrator. This individual is primarily responsible for ensuring that staff knows how to deal with the media (i.e., what to say or to whom to refer them), for creating an environment that facilitates media cooperation with school requests, and (if necessary/appropriate) arranging for interviews. Additionally, this individual plays an important role in creating the school's public acknowledgment of the suicide and in determining how this information will be shared with staff, students, parents, community, and the media.

Medical Liaison. The medical liaison is typically a school nurse. This individual's primary responsibilities include implementing plans designed to ensure student health following a crisis and acting as a liaison with medical personnel. For example, if a suicide attempt results in a hospitalization, the medical liaison is responsible for keeping the crisis response team informed of the individual's medical status.

Security Liaison. The security liaison is typically a school administrator. This individual's primary responsibilities include implementing plans designed to ensure student safety following crises and acting as a liaison with local law enforcement officials. For example, following some suicides, crowd control may become a problem (Davis & Sandoval, 1991). If a student suicide takes place at a particularly public school site, and students are aware of this fact, large numbers of students may congregate at this location. In such a situation, the security liaison is responsible for the appropriate crowd control procedures. This liaison also is the person from the school who has contact with the local police department and may be one of the first team members contacted about a suicide. In addition, it might be appropriate to have someone, such as the security liaison, walk the halls to monitor common areas such as bathrooms, parking lots, and cafeterias. This allows the crisis response team to monitor and connect with students in need who are not in their classrooms (Berman & Jobes, 1991).

Assess the Suicide's Impact on the School and Estimate the Level of Postvention Response

Once assembled, the crisis response team should immediately begin to assess the impact of the death on the school. As mentioned, the first issue to consider is whether a postvention is needed. If it is judged that students will become aware of the death and will have difficulty coping with the loss (as was likely the case following James' death), the next step is to estimate the level of the postvention response required. Levels of response range from focusing on just a few individuals to an entire school. Accurately estimating the required response is important because there are dangers associated with both under- and overreacting to crises (Brock, Sandoval, & Lewis, 2001). Underreacting may result in postvention assistance not being available to those who need such support. The scenario presented at the beginning of this chapter is an example of underreaction. Conversely, overreaction runs the risk of sensationalizing the death.

Assessment of a suicide's impact on a school primarily involves estimating the number of students affected by the death. Temporal proximity to other traumatic events, particularly prior suicidal crises, also will be important in determining the impact of a suicide. If other suicides have recently affected the school and/or community, then the current suicide may be an indication of a suicide cluster. Obviously, if this is the case, its impact on the school and community will be greater and a more involved postvention response is required. Finally, the school should consider the timing of the suicide. If the suicide occurred during a vacation, then its impact on the school may be less intense than if it occurred while school was in session (Brock & Sandoval, 1997).

Determining the number of individuals affected by a suicide requires identifying those who were physically and/or emotionally proximal to the suicide. (See Chapter 19, Identifying Individuals at Risk for Psychological Trauma, in this volume.) Students who were physically proximal to the suicide include those who witnessed the suicidal behavior and/or discovered the body. These individuals are at risk for symptoms of posttraumatic stress and more severe grief reactions (Brent et al., 1992; Callahan, 2000). The greater the number directly exposed to this event, the greater the level of postvention response. Students who were emotionally proximal to the suicide include those who were friends, close associates, or who otherwise identified with the suicide victim. These individuals are particularly vulnerable to major depression (Brent et al., 1992). Here again, the greater the number of students emotionally close to the suicide victim, the greater the level of postvention response. For example, following James' suicide, while only one student would be considered physically proximal to the death (the friend who discovered James), many might be considered emotionally proximal. James was a popular, well-liked student. Thus, many students will likely find it difficult to cope with this loss, and the postvention will need to address a large number of students. Conversely, if James had not been well known (e.g., had just moved to the school) then the response would be relatively limited. In such a circumstance, it might only focus on the student who discovered James and on his ex-girlfriend.

Notify Other Involved School Personnel

With assessment of impact and estimated response needs in mind, the crisis response team should next contact other school personnel who will likely be affected by the death and/or will participate in the postvention response. Ideally, these notifications are made within the first hour following verification of the death (Garfinkel et al., 1988, Fall). At the very least, this information needs to be provided to school personnel before the loss is publicly acknowledged.

District office. Once word of a suicide reaches the community, it is not uncommon for district-level administrators to receive calls from concerned citizens as well as from the media. Thus, it is critical that they have knowledge of what happened and what is being done to assist students to cope with the tragedy (American Association of Suicidology, 1998). If needed, additional postvention support is typically obtained from the district office.

Other potentially affected school sites. The crisis response team should also notify other schools potentially affected by the death. In determining the potential for such an effect, it will be important to consider whether the student(s) involved in the crisis have siblings and/or friends that attend other schools. Similarly, if a school staff member is the suicide victim, it will be important to examine whether former students, now attending different schools, may be affected (Brock & Sandoval, 1997).

Staff members at the school(s) affected by the death. All school staff members should be informed of a death as soon as possible (Siehl, 1990). This knowledge will give staff members a chance to confront their own emotional reactions before being asked to help students cope. If the death occurred during nonschool hours, this information should be disseminated before staff members arrive at school (American Association of Suicidology, 1998), for example, by using a previously established telephone tree (see Brock, Sandoval, & Lewis, 2001, for an example). If the death occurs during school hours, this information can be disseminated by sending a crisis response team member to each classroom to individually inform teachers (Wenckstern & Leenaars, 1993) and/or by a brief staff meeting at the end of the school day.

Contact the Family of the Suicide Victim

Contact with the family of the suicide victim will often be one of the first postvention tasks as the school attempts to verify the facts. This contact should be made in person (Poland & McCormick, 1999) within 24 hours of the death (Siehl, 1990).

The goals of family contact typically include expression of the school's sympathy and, if needed, the offering of postvention assistance (Davis & Sandoval, 1991). The family can also be helpful in identifying any of the victim's friends who may need assistance (American Association of Suicidology, 1998). If appropriate, the school's postvention response may also be discussed (Wenckstern & Leenaars, 1993); however, this activity might be delayed until the team has a more concrete idea of what to include in the postvention.

It is recommended that a crisis team member discuss with the student's parents which details about the death can be shared with outsiders (Roberts et al., 1998). Family members can be told that school staff will not discuss or speculate on family problems or other reasons why the individual committed suicide (Poland & McCormick, 1999; Roberts, 1995). It is typically inappropriate, however, to keep secret the basic fact that the death was a suicide, even if the family requests it (American Association of Suicidology, 1998).

Determine What Information to Share About the Death

After contacting the family of the suicide victim, the crisis response team should make decisions about what to tell staff, students, parents, and the media about the death. The team can make these decisions as soon as it has verified the death. The team should make an announcement regarding the death within the first hour after verification (Garfinkel et al., 1988). It is critical that this message be delivered as soon as possible. The longer the school delays in sharing the facts, the greater the likelihood that damaging rumors will start. Because not all of the facts may be immediately available, the team may need to provide several different communications.

Before a death is certified as a suicide. Because cause of death certification can be complex, the initial public acknowledgment of the loss will often occur before the death is certified as a suicide. Thus, the initial message will typically avoid identifying the death a suicide. Instead, the school may simply report that a death has occurred, acknowledge the uncertainty regarding cause of death, and offer an expression of sympathy. Sometimes even the most obvious of suicides are classified as accidents. Furthermore, some families will go to great lengths to cover up suicide. Consequently, it is important for the crisis response team members to restrict their comments to documented facts and to avoid speculation (Garfinkel et al., 1988). As more information becomes available (e.g., a death is classified as a suicide), the crisis response team will need to continue to determine what information to share.

After a death is certified as a suicide. Once the death is officially ruled a suicide, the crisis response team should directly acknowledge this fact. This message should also mention the danger of contagion, indicate suicide warning signs, and offer information about crisis intervention referrals (American Association of Suicidology, 1998). Even after all the facts are available, the response team must continue to exercise discretion regarding the kind of information it shares. As mentioned, excessive detail should not be provided. In addition, it is critical to avoid presenting information that might either glorify or vilify the suicide victim. Both types of messages may sensationalize the death and facilitate identification with the victim. Additionally, vilifying the decedent may isolate those who identify with the victim (O'Carroll et al., 1988). The focus of the school's message should be grieving and seeking to learn from the tragedy.

Provide facts and dispel rumors. Although excessive detail should be avoided, it is essential to provide students with the basic facts. Without this knowledge, sensational rumors will quickly proliferate (Leenaars & Wenckstern, 1998). Typically, these rumors are more anxiety-provoking than are the facts (American Association of Suicidology, 1998). When creating a message regarding the death, the crisis response team must be sensitive to these rumors and provide the appropriate information. Davidson (1989) emphasizes this necessity and suggests that rumors predicting additional suicides lend significant notoriety to further suicides. From these observations, Davidson concludes it is essential that the school make available information needed to dispel such rumors.

Determine How to Share Information About the Death

After crafting the basic message regarding the death, the next step for the crisis response team is to make decisions about how to share the message with students, parents, and the media. Options include written bulletins, letters, phone calls, classroom presentations/discussions, and individual conferences (Davis & Sandoval, 1991). This message should be disseminated as soon as possible, but not before providing school personnel with the basic facts.

Reporting the death to students. It is recommended that crisis response teams avoid sharing information about the death over a school's public address system or, in most cases, in a schoolwide assembly (Wenckstern & Leenaars, 1993). Rather, it is better for the message to be delivered simultaneously in classrooms where a familiar staff member can be present to handle students' concerns directly (American Association of Suicidology, 1998; Berman & Jobes, 1991; Ruof & Harris, 1988; Siehl, 1990). It may be appropriate to share information individually or in small groups with students who are particularly vulnerable or who were close to the student who committed suicide. For example, in the scenario presented at the beginning of the chapter, this would include James' ex-girlfriend.

Reporting the death to parents. Information regarding the death is typically reported to parents in a letter written by the school principal. However, a school official should personally provide this information to the parents of the most affected students (e.g., James' ex-girlfriend). It may also be appropriate to schedule a parent's meeting to address parental concerns more directly and to offer guidance on how they can help their children. During such group meetings, it is recommended that enough crisis intervention team members be on hand to allow for individual and small group consultations (J. Kalafat, personal communication, March 15, 2001). In my experience it is best if the media are excluded from parent meetings.

Working with the media. To further ensure that the death is not sensationalized, the media liaison should work with the press to downplay the incident (e.g., by placing the story on an inside page of the paper or preferably by not reporting it at all).[4] It is essential that the media not romanticize the death or in any way make a celebrity out of the suicide victim. In addition, instead of presenting the behavior as a response to normal stress, the media should be encouraged to emphasize the pathological aspects of suicide (Davis & Sandoval, 1991). It is recommended that a photo of the suicide victim not be included and that the word "suicide" not be placed in the caption (Ruof & Harris, 1988). These recommendations are based on research suggesting that nonfictional media coverage of suicide is associated with increases in the suicide rate (Davis & Sandoval, 1991; Gould, 1992). Further justification for these reporting recommendations is offered by Davis and Sandoval (1991) who point out that, if suicide is viewed as providing significant attention, it might encourage imitative behavior.

Ideally, the groundwork for media relations will have been completed before the suicide. According to Davis and Sandoval (1991), "Close work with reporters and editors can create positive voluntary guidelines for reporting suicides" (p. 168). For example, in addition to compliance with the mentioned reporting issues, the media might agree to include information about community resources that are available for those with suicidal thoughts. When appropriate, the media liaison coordinates press interviews with school staff. Student interviews should not occur without prior parental consent. Furthermore, it is essential that all staff know what information to give out and with whom to share it or know to whom to refer all inquiries (e.g., media liaison, principal, crisis response coordinator, or the district office).

Identify Students Significantly Affected by the Suicide and Initiate Referral Procedures

The school should initiate identification of students significantly affected by the suicide as soon as possible. The school should maintain a list of all these individuals to ensure that no one "slips through the cracks" and to facilitate long-term follow-up. Garfinkel et al. (1988, Fall) suggest that this process begin within the first three hours following verification of the death.

From their assessment of the impact of the death on the school, the crisis response team will have already begun to identify students and staff most significantly affected by this loss. As discussed, physical and/or emotional proximity to the suicide are key variables to identify affected students. For example, from the research of Brent et al. (1992) and Callahan (2000) it is recommended that special attention be given to those who witnessed the suicide and/or were exposed to the suicide victim's body at the scene of the death. Such exposure is reported to be correlated with the severity of grief and/or posttraumatic stress reactions. In addition, special attention should be given to those who had close relationships with the suicide victims because they are at risk for depression.

Special efforts should be directed toward identifying students who are most likely to be at high risk for suicide themselves as part of a suicide cluster (Davidson, 1989). According to the federal Centers for Disease Control (CDC) (O'Carroll et al., 1988), these individuals include siblings and friends of the suicide victim, previous suicide attempters, those who are clinically depressed, and those who have limited social resources. The CDC recommends that persons judged to be at high risk should be identified, and a trained counselor should provide at least one screening interview. Although it is critical that high-risk students be the focus of postvention efforts, Davis and Sandoval (1991) recommend making such assistance available to any student who wants to talk about the death. Table 2, on page 566, summarizes additional information regarding factors that might place a student at risk for imitative suicidal behavior.

It is likely that the informed local crisis response team will be able to unilaterally identify many of the most significantly affected individuals. However, it is equally likely that they will not be able to independently identify all affected students. Thus, as part of effective postvention, it is essential that a crisis response team ensure that a referral mechanism is in place. This mechanism should provide vehicles for teachers, parents, and students to bring individuals to the attention of the crisis intervention team. It should include a self-referral procedure.

Conduct a Faculty Planning Session

As mentioned, one of the very first actions of the crisis response team is informing the school staff of the death. In addition to this initial communication, a faculty planning session (which, as appropriate, may include noncertificated as well as certificated school personnel) should be held (Berman & Jobes, 1991; Davis & Sandoval, 1991). This meeting should provide school staff members with updated information regarding the death and, if available, news articles about the death (American Association of Suicidology, 1998).

The crisis response team should provide staff with background knowledge important to being part of the suicide postvention process (Siehl, 1990) and clarify their postvention roles. Specifically, staff should receive information about suicide contagion (Poland & McCormick, 1999), suicide risk factors (American Association of Suicidology, 1998), and plans for the provision of crisis intervention services (Thompson, 1990).

Ideally, teachers are an important part of the postvention process. Specific activities for teachers following a suicide include replacing rumors with facts, encouraging the ventilation of feelings, and stressing the normality of grief and stress reactions. They also can discourage attempts to romanticize the suicide, be aware of students who appear at risk for an imitative response to the suicide, and make appropriate referrals (Berman & Jobes, 1991). While it is important for teachers to be prepared to suspend their normal class routine in order to engage in suicide postvention, it is essential to

Table 2

Risk Factors for Imitative Suicidal Behavior

Risk Factor	Examples
Facilitated the suicide	• Involved in a suicide pact. • Helped to write the suicide note. • Provided the means for the suicide. • Knew about and did not try to stop the suicide.
Failed to recognize the suicidal intent	• Did not take a suicide threat seriously and/or kept a suicide threat a secret. • Observed events that they later learned were signs of suicidal thinking. • Had not responded to the victim's request for help.
Believe they may have caused the suicide	• Feels guilty about things said or done to the victim before the suicide. • Had recently punished or threatened to punish the victim.
Had a relationship with the suicide victim	• Mentioned in the suicide note. • Boyfriend or girlfriend. • Relatives. • Friends. • Was in the same social network as suicide victim. • Self-appointed therapists.
Identify with the suicide victim	• Identifies with the victim's situation. • Views the victim as a role model. • Believes that life circumstances parallel the suicide victim's.
Have a history of prior suicidal behavior	• Previously attempted suicide. • Are preoccupied with death or suicide. • Have family members or acquaintances that have died by suicide, accident, or homicide. • Have a history of impulsive or violent behavior that is directed toward either self or others.
Have a history of psychopathology	• Have poor baseline mental health. • Are clinically depressed. • Have a substance abuse problem. • Have been hospitalized for emotional, drug and/or alcohol problems.
Show symptoms of helplessness and/or hopelessness	• Are desperate and now consider suicide a viable alternative. • Feel powerless to change distressing life circumstances.
Have suffered significant life stressor or losses	• Have family members and/or friends who have died by accident or homicide. • Recently broke up with a girlfriend or boyfriend. • Have been disrupted by more frequent changes in residence, schools, or parental figures.
Lack social resources	• Have few friends. • Do not have a supportive family.

Note
Adapted from information provided by American Association of Suicidology (1998); Brent et al. (1989); Callahan (2000); Davidson (1989); Davidson, Rosenberg, Mercy, Franklin, & Simmons (1989); Gould (1992); O'Carroll et al. (1988); Ruof & Harris (1988); and Sandoval & Brock (1996).

BEST COPY AVAILABLE

keep school open and to follow the normal bell schedule. Such continuity is important and reassuring for the survivors of any crisis event (Berman & Jobes, 1991; Davis & Sandoval, 1991).

In addition to helping staff anticipate student reactions and questions regarding the death, the faculty planning session should provide a forum to address staff issues. In this meeting faculty should have an opportunity to further process their own feelings of grief, guilt, and/or anger (Davis & Sandoval, 1991). In fact, it might be argued that dealing with these feelings is an important prerequisite before the faculty can effectively assist students to cope. In agreement with this observation, Ruof and Harris (1988) state:

> The single best predictor of how students will respond to a frightening event is how the adults around them are reacting. Being able to work through the effects of a suicidal death with caring, supportive adults will decrease the contagion. Any kind of death is hard for adolescents, but it is especially hard if adult guidance and support is withheld. (p. 8)

Finally, it is important to point out that staff members should be given permission to feel uncomfortable discussing the suicide with their students. Each crisis is unique, and everyone has particular difficulty dealing with certain situations. It is important to respect feelings of discomfort and understand that, in some cases, such feelings may interfere to the point that a staff member may not be able to provide students with needed support and guidance. These individuals should be given alternative opportunities for participating in the postvention. It is appropriate to provide some teachers with direct assistance from a crisis response team member as they engage in this difficult task.

Initiate Crisis Intervention Services

As individuals in need of assistance are identified, crisis intervention should be provided. Ideally, these interventions are initiated within the first 24 hours following the death (Leenaars & Wenckstern, 1998). Intervention options include (a) individual meetings, (b) group crisis intervention, (c) classroom activities and/or presentations, (d) parent meetings, (e) staff meetings, and (f) referrals to community agencies (Davis & Sandoval, 1991; Morrison, 1987). Davidson (1989) suggests that the smaller group counseling sessions (as opposed to schoolwide assemblies) provide the most appropriate environment for addressing student needs and concerns.

When considering crisis intervention options, keep in mind that survivors of suicide indicate that the most supportive and positive assistance comes from other survivors (Thompson & Range, 1992). Thus, forming groups of similarly affected students is a recommended initial intervention. In addition, it is important to acknowledge that the presence of social and emotional support is correlated with less distress among suicide survivors (Callahan, 2000). Thus, interventions aimed at facilitating such support are also recommended (e.g., ensuring that parents are available to their children).

Walk through the suicide victim's class schedule. It is important for the crisis response team to ensure that a team member is available to walk through the suicide victim's class schedule to help students in those rooms who are affected by the "empty chair" (Berman & Jobes, 1991). In doing so the team member should help the teacher discuss the death, encourage questions and expression of feelings, clarify misconceptions, and make plans for the expression of sympathy (e.g., knowing what to expect at a funeral) (Wenckstern & Leenaars, 1993).

Meet separately with individuals who were physically and/or emotionally proximal to the suicide. Separate groups should be established for those who were proximal to the suicide (i.e., close friends of the victim, witnesses of the suicide or its aftermath). For example, a separate meeting would be held for James' ex-girlfriend as well as the friend who discovered the body. Students should be helped to express their feelings about the suicide and told that it is normal to feel grief as well as fear, guilt, anger, and confusion.

Among those who were physically and/or emotionally close to the suicide, crisis reactions may be so severe that a mental health diagnosis may be appropriate. Common among those directly exposed to the suicide (e.g., the friend who found James after he shot himself) is posttraumatic stress disorder (PTSD) (Brent et al., 1992; Knieper, 1999). School-based mental health professionals do not typically provide treatment for such conditions; however, school personnel must be cognizant of the signs regarding the need for such treatment. It is desirable for school personnel to be aware of appropriate treatment options. Specific treatments that may be offered to survivors of suicide are discussed by Knieper and include the following: (a) individual therapy, (b) Rational Emotive Behavioral Therapy, (c) systematic desensitization, (d) Person-Centered Therapy, (e) Eye Movement Desensitization and Reprocessing, (f) group therapy, and (g) medication.

It is important to acknowledge that during crisis intervention some students may become quite emotional when expressing feelings about the death. These students will need to be provided individual crisis intervention. Under no circumstances should a student who appears upset be allowed to leave school without informed parental consent (Poland & McCormick, 1999).

Establish ongoing drop-in counseling centers. As a part of the previously mentioned self-referral procedures, schools should establish counseling centers. Inform students that they can come to these centers to talk about the suicide at any time during the school day. Another option to consider is making such service available during nonschool hours. These centers should maintain operations for several days following a suicide (J. Kalafat, personal communication, March 15, 2001).

Facilitate dis-identification with the suicide victim. As mentioned earlier, a critical intervention task is to ensure that students do not identify with the suicide victim. Crisis intervenors should not romanticize or glorify the victim's behavior or circum-

Table 3

Crisis Intervention Procedures and Objectives Following a Suicide

Intervention Procedures	Intervention Objectives
1. Without going into excessive detail, provide students with the facts about the suicide.	1. Students should be able to distinguish between crisis facts and rumors.
2. State that the only one ultimately responsible for the suicide is the victim.	2. Make sure students do not dwell on real or imagined guilt.
3. Acknowledge that the suicide was an avoidable and poor choice. Portray the act as a permanent solution to temporary problems.	3. Students understand death is permanent and that the suicide victim will not gain any satisfaction from postmortem events.
4. Discuss how the survivors are different from the suicide victim. Portray the suicide victim as very upset, disturbed, and as someone who had not found an effective way to work out problems. Help survivors to dis-identify with the suicide victim (without abusing the victim's character).	4. Students do not identify or romanticize with the victim's behavior or circumstances. Students are less likely to view suicide as a coping strategy when dealing with adversity.
5. Facilitate the expression of feelings about the suicide.	5. Students should understand that not only grief, but also guilt, fear, anger, and confusion are normal reactions.
6. State that there is no "right way" to feel after a suicide.	6. Students should accept as normal a number of different reactions.
7. Point out that painful reactions to the suicide will be alleviated with time and talk.	7. Students should anticipate that with emotional support (such as is provided by postvention) they will be able to cope with this loss.
8. Acknowledge that people may have suicidal thoughts following the suicide of a significant other.	8. Students should understand fleeting thoughts of suicide are not unusual. However, persistent and intrusive suicidal ideation is an indication of the need to seek mental health assistance.
9. Provide information about the warning signs of suicidal behavior and available mental health resources.	9. Ensure that students are able to recognize the warning signs of suicide and know how to refer both themselves and their peers for crisis intervention assistance.
10. If appropriate, prepare students for the funeral.	10. Students who choose to attend the funeral should know what to expect.

Note
Adapted from information provided by American Association of Suicidology (1998); Berman & Jobes (1991); Davis & Sandoval (1991); O'Carroll et al. (1988); Poland & McCormick (1999); Ruof & Harris (1988); and U.S. Department of Health and Human Services (1999).

BEST COPY AVAILABLE

stances and should not dwell on real or imagined guilt (Davis & Sandoval, 1991). Instead, they should point out how students are different from the suicide victim. "Don't say the death was unexplainable, e.g., 'He had everything thing going for him'; say instead, 'There were serious things troubling him that we may never know about'." (Ruof & Harris, 1988, p. 8). The suicide victim should not be made admirable by emphasizing only positive traits. Instead, crisis intervenors should point out that suicide was a poor choice (Ruof & Harris, 1988). Table 3, on page 569, provides a summary of suicide postvention procedures and objectives.

Parental contact. Finally, whenever there is concern regarding suicidal ideation, students who are minors must not be allowed to leave school until school staff has personally met with a parent or guardian. In addition, the parents of all students identified by the crisis response team as the focus of the postvention response should be individually notified.

Daily Planning Sessions

After initiating suicide postvention interventions, the crisis response team should meet at least once each day (typically the end of the school day) to review the intervention's progress and to make additional plans (Berman & Jobes, 1991). As appropriate, the rest of the school's staff may be included in parts of these planning sessions. These meetings also ensure that crisis response team and other school staff members continue to be able to assist in the postvention process. As with other forms of crisis intervention, suicide postvention is extremely stressful. Thus, it is possible that some staff members will not be able to continue with this difficult task.

Memorials

After a crisis event, many people feel the need to express their grief, say good-bye, and participate in a memorial. Whether students wish to attend a funeral should be up to the students and their parents. School staff members may wish to inform students who are interested in attending what is likely to occur at the funeral since this may be the first death in the lives of many students (Berman & Jobes, 1991). Making special arrangements to send students from school to funerals is not recommended; however, students who have parental permission should be allowed to attend if they so choose (Poland & McCormick, 1999). Similarly, it is not recommended that a memorial or funeral service be held at school (Ruof & Harris, 1988). If the funeral is during school hours, it is suggested that school *not* be canceled (Davidson, 1989). Finally, the school should advise the victim's family and minister of the need to distance the suicide victim from survivors and to avoid glorifying the act. Ruof and Harris (1988) suggest that this advice is typically well received when delivered in a supportive fashion from a respected school official.

Following a crisis, staff members and students need to do something to prevent the crisis event from reoccurring. For example, staff may enlist student aid in identifying

Table 4

Memorial Activities Following a Suicide

Do . . .	Do not . . .
• something to prevent other suicides.	• send all students from school to funerals, or stop classes for a funeral.
• develop living memorials, such as student assistance programs, that will help others cope with feelings and problems.	• have memorial or funeral services at school.
• allow students, with parental permission, to attend the funeral.	• put up plaques in memory of the suicide victim, or dedicate yearbooks, songs, or sporting events to the suicide victim.
• encourage affected students, with parental permission, to attend the funeral.	• fly the flag at half-staff.
• mention to families and clergy the need to distance the person who committed suicide from survivors and to avoid glorifying the suicidal act.	• have assemblies focusing on the suicide victim, or have a moment of silence in all-school assemblies.

Note
From "Suicidal ideation and behaviors" (p. 372), by S. E. Brock & J. Sandoval. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems, and alternatives*, 1997, Bethesda, MD: National Association of School Psychologists. Copyright 1997 by the National Association of School Psychologists. Adapted with permission.

the hurts that led to suicide and discuss ways to help other students cope with their feelings and problems. Special interest groups may grow out of students' need to do something to express their feelings. It may be appropriate to assist the students in planning a living memorial. Working together on such a project can help focus grief, fears, and anger in a constructive manner.

When choosing memorials following a suicide, take particular care not to romanticize or stigmatize the act of suicide. Ruof and Harris (1988) state: "Avoid providing opportunities for students to glamorize or romanticize the death. Don't put up plaques or dedicate yearbooks, songs or sporting events to the victim" (p. 8). Similarly, Garfinkel et al. (1988) recommend against flying the school flag at half staff, having a moment of silence in an all-school assembly, having a memorial service at the school, or having a memorial page in the school yearbook. Controversies regarding memorials, such as whether to fly flags at half-staff or not, can be avoided by having in place previously developed universal policies that apply to all deaths (J. Kalafat, personal communication, March 15, 2001). Table 4 provides a summary list of memorial activity "Do's" and "Don'ts."

Debrief the Postvention Response

At the conclusion of the postvention, a debriefing must be provided for all those who helped in the crisis intervention (Ward, 1995). Goals include a review and evaluation of all crisis intervention activities and making plans for follow-up actions. Perhaps most importantly, however, the debriefing is an opportunity to help crisis intervenors cope with the crisis. It is not uncommon for "caretakers" to deal with their grief by denying it and directing their energy to caring for others. This meeting provides an opportunity for mutual support and helps crisis intervenors to deal with their own emotions and feelings (Davidson, 1989).

Summary

Once a death has been verified and the crisis response team mobilized, the first postvention action is assessment of the death's impact on the school and estimation of the level of postvention response. The next task involves communication with school personnel and the family of the suicide victim(s). After these contacts, the crisis response team will be in a position to make decisions about what and how information is to be shared with students, parents, and the media. In making these decisions the team must keep in mind the need to avoid sensationalism, glorification, or vilification, or providing excessive detail about the death. Identification of students who will be the focus of the suicide postvention occurs next, and is facilitated by the establishment of a referral mechanism. With identified students in mind, the postvention response needs to be planned. A variety of interventions may be appropriate. However, it is important to ensure that a crisis response team member is available to walk through the suicide victim's class schedule and that separate meetings are held for the victim's close friends. A memorial is a topic that deserves special consideration during the planning sessions that should occur on a daily basis. Finally, it is essential that all personnel who participated in the postvention responses be debriefed.

References

American Association of Suicidology. (1998). *Suicide postvention guidelines: Suggestions for dealing with the aftermath of suicide in the schools*. Washington, DC: Author.

Berman, A. L., & Jobes, D. A. (1991). *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association.

Brent, D. A., Kerr, M. M., Goldstein, C., Bozigar, J., Wartella, M., & Allan, M. J. (1989). An outbreak of suicide and suicidal behaviour in a high school. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*, 918-924.

Brent, D. A., Perper, J., Moritz, G., Allman, C., Friend, A., Schweers, J., Roth, C., Balach, L., & Harrington, K. (1992). Psychiatric effects of exposure to suicide among the friends and acquaintances of adolescent suicide victims. *Journal of the American Academy of Child & Adolescent Psychiatry, 31*, 629-639.

Brock, S. E., & Sandoval, J. (1997). Suicidal ideation and behaviors. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 361-374). Bethesda, MD: National Association of School Psychologists.

Brock, S. E., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Callahan, J. (2000). Predictors and correlates of bereavement in suicide support group participants. *Suicide & Life-Threatening Behavior, 30*, 104-124.

Centers for Disease Control. (1994). Programs for the prevention of suicide among adolescents and young adults; and suicide contagion and the reporting of suicide: Recommendations from a national workshop. *Morbidity and Mortality Weekly Report*, 43(RR-6).

Davidson, L. E. (1989). Suicide cluster and youth. In C. R. Pfeffer (Ed.), *Suicide among youth* (pp. 83-99). Washington, DC: American Psychiatric Press.

Davidson, L. E., Rosenberg, M. L., Mercy, J. A., Franklin, J., & Simmons, J. T. (1989). An epidemiologic study of risk factors in two teenage suicide clusters. *Journal of the American Medical Association, 262*, 2687-2692.

Davis, J. M., & Sandoval, J. (1991). *Suicidal youth: School-based intervention and prevention*. San Francisco, CA: Jossey Bass.

Diekstra, R. F., & Garnefski, N. (1995). On the nature, magnitude, and causality of suicidal behavior. *Suicide & Life-Threatening Behavior, 25*, 36-57.

Garfinkel, B. D., Crosby, E., Herbert, M. R., Matus, A. L., Pfeifer, J. K., & Sheras, P. L. (1988). *Responding to adolescent suicide*. Bloomington, IN: Phi Delta Kappa Task Force on Adolescent Suicide.

Garfinkel, B. D., Crosby, E., Herbert, M. R., Matus, A. L., Pfeifer, J. K., & Sheras, P. L. (1988, Fall). Responding to adolescent suicide - the first 48 hours. *News, Notes, and Quotes*, pp. 12-13.

Gould, M. S. (1992). Suicide contagion. *Lifesavers, 4*, 4.

Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide & Life-Threatening Behavior, 31* (Suppl.), 6-31.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide & Life-Threatening Behavior, 31*, 91-102

Knieper, A. J. (1999). The suicide survivor's grief and recovery. *Suicide & Life-Threatening Behavior, 29*, 353-364.

Lamb, R., & Dunne-Maxim, K. (1997). Postvention in schools: Policy and process. In E. J. Dunne, J. L. McIntosh, & K. Dunne-Maxim (Eds.), *Suicide and its aftermath: Understanding and counseling the survivors* (pp. 245-260). New York: Norton.

Leenaars, A. A., & Wenckstern, S. (1998). Principles of postvention: Applications to suicide and trauma in schools. *Death Studies, 22*, 357-391.

Mauk, G. W., Gibson, D. G., & Rodgers, P. L. (1994). Suicide postvention with adolescents: School consultation practices and issues. *Education and Treatment of Children, 17*, 468-483.

Mishara, B. L. (1999). Concepts of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide & Life-Threatening Behavior, 29*, 105-118.

Morrison, J. L. (1987). Youth suicide: An intervention strategy. *Social Work, 32*, 536-537.

Moscicki, E. K. (1995). Epidemiology of suicidal behavior. *Suicide & Life-Threatening Behavior, 25*, 22-35.

National Center for Injury Prevention and Control. (1998). *Scientific data, surveillance and injury statistics*. Atlanta, GA: Centers for Disease Control and Prevention. Available Online: www.cdc.gov/ncipc/osp/mortdata.htm

O'Carroll, P. W., Mercy, J. A., & Steward, J. A. (1988). CDC recommendations for a community plan for the prevention and containment of suicide clusters. *Morbidity and Mortality Weekly Report, 37*(S-6), 1-12.

Phillips, D. P., & Carstensen, L. L. (1986). Clustering of teenage suicides after television news stories about suicide. *New England Journal of Medicine, 315*, 685-698.

Poland, S. (1989). *Suicide intervention in the schools*. New York: Guilford Press.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Ramsay, R. F., Tanney, B. L., Tierney, R. J, & Lang, W. A. (1996). *Suicide intervention workshop* (6th ed.). Calgary, AB: LivingWorks Education.

Reed, M. D. (1993). Sudden death and bereavement outcomes: The impact of resources on grief symptomatology and detachment. *Suicide & Life-Threatening Behavior, 23*, 204-220.

Roberts, R. L., Lepkowski, W. J., & Davidson, K. K. (1998). Dealing with the aftermath of a student suicide: A T.E.A.M. approach. *NASSP Bulletin, 82*, 53-59.

Roberts, W. B. (1995). Postvention and psychological autopsy in the suicide of a 14-year-old public school student. *The School Counselor, 42*, 322-330.

Ruof, S. R., & Harris, J. M. (1988, May). Suicide contagion: Guilt and modeling. A series on suicide prevention. NASP *Communiqué, 16*(7), 8.

Sandoval, J., & Brock, S. E. (1996). The school psychologist's role in suicide prevention. *School Psychology Quarterly, 11*, 169-185.

Siehl, P. M. (1990). Suicide postvention: A new disaster plan - what a school should do when faced with a suicide. *The School Counselor, 38*, 52-57.

Thompson, K., & Range, L. (1992). Bereavement following suicide and other deaths: Why support attempts fail. *Omega, 26*, 61-70.

Thompson, R. A. (1990). Suicide and sudden loss: Crisis management in the schools. *Highlights: An ERIC/CAPS Digest*, p. 1.

Thompson, R. A. (1995). Being prepared for suicide or sudden death in schools: Strategies to restore equilibrium. *Journal of Mental Health Counseling, 17*, 264-277.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC: Author.

Ward, B. R. (1995). The school's role in the prevention of youth suicide. *Social Work in Education, 17*, 92-100.

Wenckstern, S., & Leenaars, A. A. (1993). Trauma and suicide in our schools. *Death Studies, 17*, 151-171.

Endnotes

[1] According to O'Carroll, Mercy, and Steward (1988), a suicide cluster is defined as "a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community" (p. 1).

[2] According to O'Carroll, et al. (1988) suicide clusters account for only 1 to 5% of all adolescent suicides. Further, it must be acknowledged that some research has suggested that imitative suicidal may not be an important outcome of exposure to suicide (Brent et al., 1992).

[3] It has been reported that, "many school administrators believe that the safest course is to do nothing at all in the aftermath of the suicide of a student" (Mauk, Gibson, & Rodgers, 1994, p. 470).

[4] For a further discussion of the aspects of news coverage that may promote suicide contagion, and recommendations for how the media should report suicides, the reader is referred to the Centers for Disease Control's (1994) media guidelines. A summary of this document can be found at *www.suicidology.org/mediaguidelines.htm*

Appendix

School Suicide Postvention Checklist

___ 1. **Verify that a death has occurred.**
Contact the coroner's office to verify the death was a suicide.

___ 2. **Mobilize the crisis response team.**
The crisis response coordinator should notify the crisis intervention coordinator, the media liaison, the medical liaison, and the security liaison.

___ 3. **Assess the suicide's impact on the school and estimate the level of postvention response.**
Will students learn of the death and find the loss a coping challenge? If so, estimate the number of students who may require postvention.

___ 4. **Notify other involved school personnel.**
  ___ District office
  ___ Other affected school sites
  ___ Staff member at the school(s) affected by the death

___ 5. **Contact the family of the suicide victim.**
Express sympathy, offer support, verify facts, and identify survivors.

___ 6. **Determine what information to share about the death.**
Report verified information only. Directly attack rumors. Do not provide excessive detail.

___ 7. **Determine how to share information about the death.**
Do not sensationalize, glorify, or vilify.

___ 8. **Identify students significantly affected by the suicide and initiate a referral mechanism.**
Assess physical and emotional proximity to the suicide.

___ 9. **Conduct a faculty planning session.**

___ 10. **Initiate crisis intervention services.**
Walk through the suicide victim's class schedule. Meet separately with the suicide victim's close friends. Establish ongoing drop-in counseling centers. Facilitate disidentification with the suicide victim.

___ 11. **Conduct daily planning sessions.**

___ 12. **Plan memorials.**
Plan for funerals and other memorial activities. Be sure not to romanticize or sensationalize the death.

___ 13. **Debrief personnel involved in the postvention response.**

28

School and War

危機

Avigdor Klingman, Ph.D.
University of Haifa, Israel

During the 1991 Gulf War, following threats by an Iraqi spokesman to "burn out half of the state," SCUD missiles were launched from Western Iraq and hit densely populated areas in Israel. In response to this threat, homes created sealed rooms and citizens were instructed to carry gas masks and other protective measures with them at all times. Children (some sleeping in their parents' bedroom) were awakened by sirens at night, hurried to the sealed rooms, and required (sometimes against their will) to put on gas masks. After missile attacks, people were instructed to remain in their sealed rooms for long periods of time, while the nature of the attacks was investigated to determine if there was a danger of chemical or biological agents. Closure of the schools for the first three weeks of the war deprived children of the social support of their peers, the reassurance of their teachers, and the steadying influence of familiar structures and routines at precisely the time when they most needed them. (For extended descriptions of this case see Ben-David & Lavee, 1992; Klingman, 1992a; Solomon, 1995).

A war is a large-scale protracted active crisis, frequently characterized by an acute and continuous sense of urgency, commotion and uncertainty, extreme fluidity, and often also by a sense of forthcoming calamity. Wars are not single events; rather, they can be viewed as complex emergencies that have histories of disparity, power imbalance, or discrimination. Alarming numbers of children and adolescents worldwide are (or have recently been) experiencing wars, civil strife, and large-scale terrorism. The impact of war on young people tends to be studied and discussed in the professional literature in terms of posttraumatic stress disorder (PTSD). However, PTSD is not the only possible psychological consequence of war for youths. A whole spectrum of concurrent psychological symptoms has been indicated, including general anxiety, nervousness, worry, fear of recurrence, guilt, psychosomatic complaints, sleep difficulties, depression, behavioral problems, and grief (Jacobs & Prigerson, 2000; Klingman, 2000a, 2000b; Klingman, in press; Paardekooper, 1999). War may also have indirect consequences, including economic damage that affects parents' ability to take care of their children. All youths in war zones grow up in an atmosphere of constant fear, violence, and hatred. Some take an active part in fighting—attending violent demonstrations, throwing stones at troops, or enlisting as fighters. Adolescents may be especially keen on active fighting, thinking it will earn them adult respect.

War-related symptomatology is also typical for war refugees and displaced people, sometimes referred to as the "forgotten victims of war." About half of the world's refugees and displaced people are children and adolescents. These youths may have experienced many events that cause severe emotional and physical trauma (e.g., destruction of their own homes, violence against individuals and the whole community). They may later be faced with additional adjustment matters, such as unfamiliar surroundings, new sets of norms, isolation from natural support systems, parental vulnerability, new school standards, new languages, and more (Jones & Rutter, 1998).

This chapter aims to draw conclusions from recent war experiences and from the professional literature and to offer some general guidelines for interventions with school populations. I will not enumerate all potential strategies, procedures, and tools because many are similar to interventions used in other kinds of disasters and are discussed elsewhere in this book. Some of those interventions I discuss may still overlap, but I wish to stress their particular relevancy to, and/or unique implementation for, war situations.

Unique Crisis Issues

All crises present problems that challenge the coping resources of its victims. The nature and consequences of war, however, present numerous unique challenges to students and schools.

War Is Constant, Prolonged, and Fluid

Unlike most other disasters, war entails living under constant and prolonged threat exposure; wars can continue for weeks, months, and years. Such long duration is a factor associated with psychological trauma. In addition, because war may present constantly changing conditions, fluidity of circumstances is typical and may require constant adaptation of existing, or development of new, coping strategies.

Anticipatory Period

Frequently, the eruption of war is predictable. Thus, an anticipatory guidance program can be initiated to help youths and schools cope with impending emergencies beforehand. These preparatory activities, however, may in themselves become psychologically traumatic (e.g., details regarding unconventional warfare and learning to wear gas masks) and require crisis intervention assistance.

Unique Stimuli

Wars present exposure to unique stimuli. For example, they may require youths to cope with unprecedented and, thus, unpredictable issues related to chemical and bacteriological war, or to face "conventional" war's cruel activities and civilian atrocities (e.g., in former Yugoslavia, harming woman and children was even a strategy of war). Such adversity has a cumulative effect. As young people experience these adversities of war they are likely to sense a foreshortened future, because their "assumptive world" has changed (Janoff-Bulman, 1992). Consequently, it is essential to assist students in dealing with their futures as well.

Physical Injury and Disfigurement

Wars may result in the injury (and disfigurement) of many young people. Bronfman, Campis, and Koocher (1998) reviewed the clinical issues involved in traumatic injury. They indicated that children must deal with loss of control, loss of self-image, dependency, stigma, isolation, intense emotionality, and fear of death. Crisis intervenors must help the young person's psychological processing of the injurious event as a central issue and assist caregivers in managing their own feelings regarding the injury. Youths who have lost significant others through violent war acts, especially if they witnessed the event, may have difficulty mourning. The emotional numbing and avoidance of trauma reminders commonly generated by such events make it difficult to come to terms with a loss.

School Closure

During most wars schools are closed for extended periods, and students are often confined to homes or crowded public shelters. This situation creates emotional and behavioral difficulties that caregivers may not know how to confront. Moreover, consulting with mental health professionals is often impractical due to war circumstances (e.g., curfew or travel limitations). Thus, it is likely that young people most in need are unable to gain access to community-based mental health support. As a result, alternative consultation pathways (e.g., via mass communication channels) need to be considered, established, and offered effectively by mental health caregivers.

Effects on Mental Health Professionals

War has a tremendous impact on everyone. Mental health personnel may even find it hard to dissociate themselves from the war ordeal, because they are exposed to the same continuous war conditions as their clients. Thus, caregivers involved in crisis intervention need long-term debriefing sessions and support systems of their own; "helping the helper" measures are crucial for war-related intervention.

Changes in Working Assumptions

In the face of war-related demands, routine professional roles must be set aside and most working assumptions underlying common school-based psychological interventions do not apply. Basic working assumptions must change because wartime mental health assistance is heavily based on the assumption that most dysfunctional phenomena that manifest themselves during war are not necessarily pathological or irreversible (i.e., that numerous behaviors considered "unhealthy" in nonwartime conditions are "natural" in wartime). It is also believed that the failure to resolve acute stress responses, or the inability to modulate distress at the time, may be critical in determining long-term outcomes (Klingman, 2000b; McFarlane, 2000). Therefore, assistance must be predominantly preventive and focus proactively on fostering healthy adaptation, enhancing situation-specific coping, and promoting stress tolerance, both for individual pupils and the school system.

New Teaching Demands

In wartime, the school's local context takes on an important psycho-educational dimension. Teaching demands shift in emphasis to address a variety of critical incidents (e.g., grief and mourning) and immediate pupil and situation-specific needs, such as introducing awareness of landmines and unexploded bombs, how diseases are transmitted, and how to maintain healthy lifestyles (e.g., training in relaxation techniques).

Damaged or Destroyed Infrastructure and Schools

During war, basic infrastructure, such as the economy, public health, medicine, education, social, and psychological services, may become restricted, impaired for a prolonged period, or even collapse. When access to community-based mental health services is disrupted, schools may become the only organized place where students can obtain mental health assistance. However, in times of war the school may be damaged or destroyed. In such cases the reopening of schools can be a challenging task. An important role for crisis intervenors may be assisting in reopening schools and resuming school activities, or assisting in creating alternative schooling arrangements. School mental health professionals may be called upon to provide diverse tasks. First of all, it is of paramount importance that schools reorganize to continue or resume some or all of their activity as soon as possible. School mental health professionals have an important role in assisting with the reorganization process or with the establishment of alternative schooling arrangements (e.g., informal study-and-recreation groups or club groups, distance learning through which students can be contacted and approached). This intervention differs radically from common peacetime models of organizational development and consultation. School mental health professionals must provide ongoing assistance to reopened schools. This assistance includes helping schools adapt to new circumstances and considering the war-related immediate mental health needs of pupils, educators, and the administrative staff.

Cultural and Developmental Issues

Children and adolescents should be allowed great latitude in choosing how they cope. Cultural, gender, and developmental differences should be considered as critical intervention dimensions (Hobfoll et al., 1991). Given the cultural differences within and between groups, generalizations must be made cautiously, while recognizing the many common responses and needs. This is true for the choice of both intervention strategies and tools. Substantial literature and accumulated experience now suggest the importance of contextual factors in shaping the experience of and response to war stress and trauma. Thus, the delivery of mental health interventions in non-Western settings must take into account prevailing cultural norms, including spiritual or religious involvement, basic ontological beliefs, and related issues (e.g., personhood and social connectedness, community, and illness). For example, in non-Western communities idioms of distress are likely to be quite different from Western conceptions (for further discussion of these issues, see Brackman & Petty, 1998; Sandoval & Lewis, 2002). This is an important point to mention because mental health professionals from other countries are often called on to assist in war-torn countries via UNICEF (e.g., Berk, 1998). Psychologists and counselors also need to be aware of, and sensitive to, whom in a given culture are acceptable providers of help (Hobfoll et al., 1991).

Children's cognitive development influences their interpretations of war events. Younger children tend not to be fully aware of the realistic threats, dangers, and potential harm. Thus, they tend to be better protected from emotional reactions and depend on parents and caregivers (e.g., teachers) to feel secure. In addition, younger children do not talk easily about their traumatic experiences; however, they are more likely to give graphic accounts of these experiences. There are many anecdotal accounts of younger children's drawings and play involving themes about trauma they experience (Yule, 1998). As children get older, they are more able to understand the implications of their situation. They tend to respond even more to the world beyond their families. Adolescence is a time when sociopolitical influences on identity are particularly powerful. Issues of self-identity, group/national loyalty, and ideology become more compelling, as well as thinking about the future. Moreover, political ideology and commitment may buffer adolescents' experience of war by allowing them to interpret their experiences as a "necessary evil" that must be endured if certain objectives are to be achieved (Garbarino & Kostelny, 1993; Muldoon & Cairns, 1999). Thus they should receive ongoing, updated, age-appropriate information, as well as opportunities to discuss these issues. If many children are connected to the Internet, they may be able to communicate with both adults (teachers, school counselors, and others) and age-mates via e-mail or bulletin boards (where messages are left for all others to read). The parties involved may even be in various parts of the world (Robson & Robson, 1998).

Crisis Intervention

Preventive Crisis Intervention Principles

Exposure to war may result in immediate or long-term impairment of mental health, or both. Prevention efforts are designed to keep pupils from developing long-term mental impairment by finding ways to reduce risk factors (Klingman, 2000b; Klingman, in press; Neria & Solomon, 1999). Preventive intervention can be divided into three categories: universal, selective, and indicated (Marzek & Haggerty, 1994). *Universal* preventive interventions are proactive measures developed for whole school populations that have not been identified on the basis of individual risk. These interventions include preparatory or anticipatory guidance and stress inoculation programs (Durlak, 1998). *Selective* interventions may be targeted to the whole school population or subgroups when the risk for developing posttraumatic symptomatology becomes imminent. In practice, mass screening for individual symptoms and behaviors that may predict PTSD are included in this category. *Indicated* preventive interventions are targeted toward individuals who are identified (preferably by school-based counseling groups) as manifesting early, minimal but detectable, symptoms foreshadowing PTSD. The aim is to prevent onset of a disorder by a decrease in situation-specific risk factors and an increase in protective factors.

Those working in prevention often emphasize the utility of a *risk and protective paradigm* (Durlak, 1998), within which protective factors fall in three broad domains. The first domain includes characteristics of the child (e.g., cognitive skills, coping skills, and personal sense of competency and control). The second area includes a strong positive relationship with at least one parent and the quality of the child's interactions with their environment (young people, especially adolescents can also support each other in wartime). The third domain involves aspects of the mesosystem and exosystem, such as school-home relations, social support network, and regulatory activities.

A preventive approach also emphasizes the salutogenic rather than the pathogenic response to stress and crisis. The *salutogenic orientation* (Antonovsky, 1979, 1980) focuses on those who are located toward the positive end of the health-ease/dis-ease continuum (i.e., remain psychologically well despite extreme adversities). Experience strongly suggests that some positive changes may emerge during times of war. War may become a great integrator (Breznitz, 1983), increasing *social cohesion* among pupils and among the teaching staff. Under stress they support each other more than during other times; traditional barriers between student groups break down. Moreover, war often brings out a strength and energy unlike anything seen at other times; older students may show extraordinarily successful and sometimes very courageous behaviors. There is also more readiness on the part of educators to consult with school mental health professionals about their own welfare, as well as about their students' difficulties. These behaviors are consistent with the recent stress literature calling attention to the resiliency phenomenon (e.g., Garmezy, 1985; Higgins, 1994).

The *continuity principle* serves as a generic guideline for preventive intervention in wartime. It stipulates that war can cause extreme disruption in the life course that may shatter basic schemata such as beliefs in one's invulnerability, trust in people, and faith in the predictability, manageability, and meaningfulness of the world (Klingman, 2000b; Klingman, in press; Omer & Alon, 1994). At least part of children's reactions is due to interruptions of school roles and activities. Thus, school-based preventive intervention aims first to achieve *organizational continuity*, restoring the connection between students and their community, by preserving old roles and focusing on pre-war resources and routines. The students are approached in or through their respective schools (i.e., a natural environment). The school system is helped to regain control and resourcefulness in adapting to the new situation, return quickly to routine functioning (however partial under the circumstances), and reestablish communication channels with its pre-war (i.e., familiar) community services. *Personal continuity* is restored through age-appropriate emotional and cognitive work that relates to the student's pre-war life, experience of the war, and (emphasizes) its meaning for the future. This work includes causal explanations for the war, reconstructing the meaning of one's life around the setbacks, and gaining a sense of mastery by exerting behavioral control over some of the threat-related events and (even more so) some aspects of everyday life. *Functional continuity* is restored by encouraging pupils to take relevant external action to resume their pre-war roles and routines as well as to try new ones tailored to the war situation. *Interpersonal continuity* concerns establishing interpersonal support by restoring social (e.g., classroom) bonds and enhancing the solidarity of the group as an antidote to war experiences.

Community-Focused Interventions

Media, telephone hotlines, and cyberspace are unique forms of community-focused intervention in wartime. These forms allow relatively easy access for individuals seeking advice or help. In addition, they place a strong emphasis on preventive intervention techniques adapted to massive use during prolonged, large-scale crisis.

Open telephone lines. An open telephone line for students was set up during the Gulf War in Israel. Because it was operated by the school system, no stigma was associated with it as was often the case with mental health centers (Raviv, 1993). In the majority of cases, it was possible to assist callers by providing information, encouraging them to continue coping, and labeling their fear reactions as "healthy" (Noy, 1992). A lesson learned from this war was that these open lines should also be established for teachers so they can obtain advice about their students' war-related problems.

Fiber optics and communication satellites. The astonishing velocity with which technological innovations advance necessitates considering their possible use for the benefit of children and adolescents, parents, and teachers in wartime, especially when schools are closed. The Internet serves as means for retrieval of information and for communication. It permits home-based, fast access to vast amounts of information from the best experts. Among the Internet's many applications are: (a) updated age-appropriate information on current events; (b) the interpretation of war-related terms and of some of the factors that led to the war; (c) information and details regarding the provision of psychological services; and (d) professional discussions serving support system groups (e.g., teachers and mental health professionals) simultaneously. Alternative modes of communication have already made it possible for many young people throughout the world to converse instantaneously. Internet communities, or "wired neighborhoods," make it possible for children and adolescents to interact without leaving home or shelter. Social virtual reality may have much in common with sociodrama and psychodrama by allowing children and adolescents to build a character and environment of their own choice and then live out for a while (whenever the need is felt) within this environment. It offers youths an opportunity to use screen graphics to build a safe, adult-free world with their own architecture and objects. This outlet may serve as a possible escape valve for anxiety and anger. By devising their own characters, with which they can interact, children and adolescents are given opportunities for self-expression and to explore the social aspects of situations. They also experience taking control (Duncum, 2000; Turkel, 1995).

The use of new computer technology for interactive mutual support programs is another option to consider. For example, children and adolescents may exchange drawings, poems, free writing, and jokes through a website. Such an interactive program can serve as a source of empowerment for children and adolescents (Byers, 1996). Some mental health applications may include guidance in self-help, as well as advising and giving answers in real-time. (For an extended discussion of the potential of cybercounseling, see Bloom and Walz, 2000.)

Mass media intervention. Whereas hotlines and the Internet contain elements more similar to selective and indicated preventive interventions, mass media intervention belongs to the category of universal preventive intervention. Community televised programs enable access for a passive audience. Such programs aim at increasing sensitivity, openness, tolerance, and flexibility in response to the war stress. During the Gulf War in Israel, a children's TV program relevant to the current situation was produced each day that enabled the transmission of informative as well as supportive messages that served the immediate needs of viewers (Raviv, 1993). Similarly, in Bosnia, a children's radio program was set up in which local children served as moderators and discussed their feelings; other children were encouraged to call in and give their opinions (Berk, 1998).

School-Focused Interventions

As with other crises, during war school interventions need to emphasize a team approach. Specific issues to be addressed at the school level include student safety, the need to establish structure and routine, and flexible learning centers.

Establishing a response team. It is not likely that school administrators alone can address all important war-related issues, nor is it likely that they can consider the necessary mental health perspective in the fluctuating situation. Thus, a response team should be established. This school team, appointed by the school principal, undertakes the following war-related tasks: (a) communications and records, (b) information and briefings, (c) liaison with support agencies, and (d) welfare support. The team helps in reevaluating the situation, mobilizing and adapting available resources to the new reality, and advising how to mobilize the natural as well as the community organizational support systems. An inter-school support team is usually established in which the principal and some staff members of a less affected school lend support to another school. The team works closely with the school principal to offer advice and support and any practical help needed. Although advice and support are always welcome, the principal and staff should be respected and encouraged in their need to retain control of the school's operation. If some schools are located in relatively remote areas or lack resources to handle an extreme or prolonged crisis situation, a regional response team can be established.

A crisis management manual. One major task for the team is constant updating of the teachers' crisis management manual or kit. This manual addresses the following: (a) school safety and precautionary measures; (b) school evacuation procedures and (detailed) alternative evacuation plans; (c) debriefing procedure instructions and suggestions; (d) descriptions of the expected "normal" war-related behavioral and emotional stress reactions by age; (e) guidance on how to identify, monitor, and deal with stress responses; (f) steps to take to ensure successful adjustment when injured students return to school; (g) principles and guidelines regarding pupils' preparation for attending funerals and making visits to wounded peers and/or school staff in hospitals and homes; (h) a list of the available support resources and their contact numbers, also indicating the functions of each emergency and psychological and social support service; (i) suggestions about mental health aspects to be integrated into everyday teaching as well as into school social life; (j) samples of relevant teaching tools; and (k) blueprints to advise parents. Graphic representations (e.g., diagrams) are an integral part of the manual. Administratively, it is most important that all the emergency data held on computer are backed up daily and stored in a separate building.

Pyramid procedure. During times of war, mental health services are best delivered by using the team approach referred to as the pyramid procedure intervention. Using this procedure a core of mental health workers are debriefed and guided in groups. They in turn train a larger group of caregivers who train teachers and parents (Gal, 1998; Macksoud, Haber, & Cohn, 1996). This procedure results in more manageable mental health caseloads. Mental health professionals form their own peer support group, their school interventions are limited to smaller (and thus more accessible) school populations (e.g., school management teams, educator groups), and they have a smaller variety of assignments. Thus, they can reach out indirectly to every student (and potentially to students' families as well).

As mentioned earlier, in wartime, mental health professionals countrywide are psychologically vulnerable. By adopting the pyramid procedure, and using professionals from other unaffected (or less affected) places, "helping the helpers" becomes more feasible. Gal (1998), for example, gives an account of one such project in the former Yugoslavia. The program involved intensive training in various trauma-relief issues along with debriefing sessions dealing with the helpers' own stress and burnout.

Teachers, who serve on the frontline of student mental health, feel personal stress and burdens of their own war experiences and, in addition, professional insecurity when confronting the effects of war among their pupils. By employing the "pyramid" procedure, school mental health professionals can meet with groups of teachers at their schools for combined debriefing and empowering workshops. These workshops consist of (a) debriefings (e.g., Mitchell & Everly, 1996), (b) relaying information from trauma psychology, (c) developing realistic work goals, (d) facilitating their ability to help students' cope, and (e) teaching the identification of PTSD. Such a workshop empowers teachers who, in turn, directly intervene with their pupils. Team building and group support (as well as self-help) are promoted, and the teachers, who voluntarily return to the ongoing teachers' group meetings led by the school mental health professional, also deal with their own distress.

Student safety. A crucial step in preventive crisis intervention in the school setting is introducing precautionary or safety measures. Students should be fully, and in an age-appropriate way, briefed on the precautionary measures taken by the school as well as the standards of behavior expected from students. Promoting safety also involves teaching students to be alert to dangers around them, avoiding certain areas, and taking certain steps when caught in dangerous situations. For example, children may be attracted by the colors of unexploded cluster bombs or mines. Younger children may have no knowledge of mine danger. Even youths who grow up surrounded by mines and unexploded bombs may become desensitized to them, and some adolescents think it is brave to be seen handling explosives.

Establishing structure and routine. Another crucial crisis intervention step is establishing structure and, consequently, a sense of relative stability, which can be achieved by having schools return to familiar routines as well as by creating new war-related ones. Wherever and whenever possible, a return to pre-war school and classroom procedures (although flexible to accommodate the changing circumstances) should be implemented.

Recreational activities. Organizing in-school, or in-town, recreational activities is an option, especially when schools have to close down. For example, following a terrorist massacre of high school students in Israel, surviving students avoided school and/or classrooms, teachers were not functioning well, and parents were anxious and upset. Students who had returned from the hospital added to the overall state of anxiety by frequently crying, openly recounting their terror dreams, and stating they did not feel safe anymore. As the school year came to a close, mental health consultants recommended planning a summer camping program adopting "camping activities." Use of such recreation programs can help communities cope and facilitates reaching out to students in need (Yanoov, 1976).

Flexible learning centers. When schools were instructed to close down for an unknown period of time during the Gulf War, Israeli educators planned flexible learning centers. The aim of these centers was to continue school-pupil contact (this program was in accord with the continuity principle) by establishing meetings with pupils and providing them with flexible learning and recreational opportunities. Pupils were provided learning tasks and materials, tutoring, and debriefing in small groups. The assignments were planned so they could be carried out both in and outside the school (as the conditions permit), with teams ready to go upon request into shelters. Such a school-based team includes teachers and a school counselor. An alternative to this may be distance-learning programs.

School Reorganization and Consultation

Organizations, like individuals, tend to resort to familiar behaviors even when they no longer work. They tend to continue well-learned responses in the face of crisis, which may lead to poor adaptation to the changing demands. The extent and severity of school response depend on the proximity of the school to the location of a strike or the physically devastating conditions and/or on the population affected. School staff absenteeism because of mobilization of teachers, travel difficulties for teachers who live quite a distance from the school, family burdens (e.g., as a consequence of the other parent's absence, damage to property), and preoccupation and concerns with their own children's safety will also impair the school's capacity to function.

When defense mechanisms fail to guarantee equilibrium, the usual resistance to change is (at least temporarily) minimized, so that long-standing differences and objections disappear (at least for some time), cooperation is improved, innovative arrangements are willingly tried out, and the need for mental health expert help is more apparent. Thus, school mental health professionals should first respond to school reorganization and crisis management utilizing considerable on-the-spot initiative and creativity. The long-term ends of school organizational change (e.g., leaving the responsibility for change with the clients) must be sidestepped. It is only through adapting the school's responses into war-related adaptive responses that educators will be able to exercise leadership and reach out to their pupils. School mental health professionals are in a position to observe and analyze the mental health aspects of school functioning and provide decision makers with reliable and relevant information.

A noted difficulty is when mental health professionals take a "surrogate leadership" position (Babad & Salomon, 1978); they may be perceived as a threat to the designated school leadership. Another difficulty is that direct intervention may reinforce anticipation of mental health professionals' "omnipotence." Thus, it is important that interventions are as indirect as possible, behind the scenes, bolstering natural support systems rather than displacing them (Caplan, 1976).

Given the reality of war situations, in which school mental health professionals are requested to guide school staff in implementing interventions, they may have to move skillfully among consultation modes. It is plausible that in wartime *coercive-directive consultation*, where decision making is unilateral rather than shared (as in the collaborative-directive approach; see Gutkin, 1999) is the method of choice. The consultants may need to be directive in their approaches to generating intervention plans. In addition, when selecting among intervention options crisis intervenors may rely primarily on their own judgment.

Classroom-Focused Interventions

The most widely used group or classroom crisis intervention is structured debriefing (Brock, 2002; Mitchell & Everly, 1996). The few controlled studies of crisis debriefing with children suggest it has a beneficial effect in treating PTSD-related response (see review by Perrin, Smith, & Yule, 2000). In the context of in-classroom prolonged war-related stress, debriefing is often best when integrated into classroom procedures and programs, employing teaching tools and techniques.

Free (and creative) writing. This strategy can serve as one means of catharsis by eliciting a direct expression of feelings and thoughts, and also by articulating and confronting difficult memories. Recent research indicates that emotional disclosure through writing about stressful events appears to have psychological and health benefits (Pennebaker, 1993). Students embrace the opportunity to disclose details of stressful situations and worries, and respond positively to such intervention. Thus, it is both feasible and valuable to give young people the opportunity to write about sources of, and responses to, stress (Reynolds, Brewin, & Saxton, 2000). It is also a means of evoking positive memories and of producing something valuable (i.e., activity, a sense of control, a sense of mastery). Free writing may also allow students to recreate their world in a new, more livable way. In-vitro exposure (such as using ambiguous photographs to trigger free writing) is one possible intervention strategy for eliciting expression of feelings when needed. Sharing of writing products enables classmates to recognize that they may not be alone in their affective response to the adversities of the war (Klingman, 1985: Phillips, Linington, & Penman, 1999). Research with children suggests that free writing is a practical procedure to use with schools in war zones and may readily be incorporated into the school curriculum (Klingman, 1985).

Bibliotherapy. This approach involves reading and discussing literary texts relevant to current problems and can also be used as a group or classroom method. With this technique students can observe war-related stressors at an emotional distance, which allows them to recognize and incorporate needed changes (e.g., in perceptions, behaviors, coping strategies) without experiencing direct personal threat. The bibliotherapy process includes identification with a story character, projection (of one's own feelings and thoughts onto this story character), catharsis, and introspection. Literary means of expression, especially working with metaphors, were found to be useful for children under war stress in both Israel and the former Yugoslavia (Klingman, 1992a; Kubovi, 1974; Zotovic, 1998). It may also serve as a diagnostic method for uncovering children's feelings of helplessness, lack of trust in the future, locus of control, coping style and resources, and other variables. Public libraries became a natural place for guided reading, or bibliotherapy, during the war in Croatia (Sabljak, 1999).

A combined bibliotherapy and free writing group intervention for children from the former Yugoslavia was studied by Krkeljic and Pavlicic (1998). Children in a group setting were asked individually to write a six-piece story. They (1) chose a hero, (2) assigned him or her with a task to fulfill, (3) wrote about the obstacles that stood in the way of carrying out the task, (4) discussed who or what could help the hero, (5) told how the hero would cope, and then (6) told what happened. The stories produced were dominated by heroes ready to fight, descriptions of endangering situations, war topics, revenge and, to a lesser degree, dealt with helping people in need and protection from the enemies. Two months later, when the prospects for the future were more certain and clear, these children were asked to write a six-piece story again. This time the hero characters lost their original aggressive touch, relying more on their own resources than on weapons, and the themes produced dealt with protective, social, and practical positive goals in addition to containing aggressive elements. Characters and situations produced can partly be understood as symbols of the circumstances that affect the children's psychological life, indicating the difficulties they are exposed to and the problems they have to solve. Certain computer games may add a new dimension to bibliotherapy by giving the operator some control over the characters' action. Students should be given the opportunity to play out their accumulated feelings of frustration, insecurity, aggression, fear, and confusion. They may actually experience first-hand encounters and events with which they are required to cope as a part of the game, and they can repeatedly play it until they master coping.

Broad-spectrum coping enhancement program. Active war situations call for "instant" skill training that is more explicit, direct, and prescriptive than during non-war situations. Following Lazarus' (1976, 1989) comprehensive and systematic range of intervention strategies, a flexible, broad-spectrum, multimodal coping and resiliency intervention program has been developed for school-based group and/or classroom intervention in war zones (Lahad, Shacham, & Niv, 2000). The six core modalities of an individual's coping style (for which the acronym *BASIC Ph* was given) are *B*eliefs (e.g., coping by making reference to self-efficacy), *A*ffect, *S*ocial (support seeking), *I*magination, *C*ognition, and *Ph*ysiology (e.g., relaxation, recreation, situation-related activity). Although anyone can potentially employ any of the six strategies, everyone has a preferred mode of coping already developed and refined through childhood. This preferred coping style reflects a combination of modalities. For example, a child whose primary coping style is Social and Imagination might seek social support from an imaginary figure, such as Superman. Working with students in wartime using the *BASIC Ph* is useful for (a) encouraging them to utilize their preferred modalities and expand them to deal with stress, and (b) introducing them to alternative modalities or helping them with alternative options within their preferred ones during various stress experiences. Inappropriate use of resources or mismatch between resources used and specific stressful situations are mapped and become the object of corrective interventions. This model has been used for both preparatory guidance and intervention in wartime.

Nonverbal and noninterpretive interventions. Expressive arts can serve as self-help therapeutic media employed by nonmental health caregivers in consultation with school mental health professionals. The war situation exacerbates excited affect and stimulates powerful projections and fantasies. Nonverbal media, through their sensory quality, may be an especially helpful intervention. Recent research has found that traumatic experiences are encoded in encapsulated nonverbal imagery (Stone, 1998). Noninterpretive art intervention enables students to spontaneously depict how they (a) experience the situation, (b) go through catharsis, (c) progressively approach the traumatic reminders, (d) get a sense of distance from the feelings by objectifying and containing them in art form, (e) talk about the images and feelings "out there," and (f) re-frame feelings to give some meaning to the confusion of the external environment (Stone, 1998). It opens lines of communication among young people themselves, as well as between student and teacher, mental health professionals, and other caregivers.

Schwarcz (1982) demonstrated the positive effect of a noninterpretive art program in wartime. An art teacher worked daily with students in their respective age groups, opening channels of symbolic activity that encouraged them to focus openly on their experiences in an active and creative way. Younger children expressed their reactions in their drawings by adding verbal captions. Older youths responded with greater diversity, some directly and dramatically, to the experience of destruction (e.g., "the moment when the houses disintegrated") and others to the personal implications (e.g., "my house destroyed and my brand new bicycle too"). Later drawings also included the shelters that saved them, representing the ambivalence associated with the shelters (i.e., anguish at having to use them and comfort in the security they provide). In the beginning, the art teacher supported the student's needs for catharsis, permitting them to regress in their drawings in the service of the ego. Later, they were gradually encouraged to move toward topics that are more benign and offered more structured sessions to enhance more cognitive and reality-oriented processes (e.g., writing letters and drawing pictures to send to soldiers). At a later stage, she talked with fourth graders about the nature of a symbol and proposed that they invent a symbol for war and for peace. She introduced sixth graders to Picasso's Guernica as an example of a symbolic expression of war, and offered seventh graders sketches of the utensils used in the shelters.

Decorating gas mask boxes was popular with children and adolescents of all ages in Israel during the Gulf War. They had to carry these boxes with them at all times, including to school (when it reopened). Besides the advantages of creative art previously mentioned, it helped disguise the frightening contents and rendered the boxes less threatening and more personal (Shilo-Cohen, 1993).

Children and adolescents experiencing war should be encouraged to draw—and write as a way to "unlock the doors" to their inner world by recalling not only the traumatic events, but also happy past memories and creating some "promising" dreams of the future. For examples, see the drawing and writings of children from the former Yugoslavia in the book *I Dream of Peace* (1995).

Creating psychological communality. Children and especially adolescents benefit from feeling that they are an integral part of a group and the broader community. In protracted wartime conditions, even hobby groups can fill the young person's need to be a part of a broader community (Hobfoll et al., 1991). Such groups should be task- and future-oriented, consisting of manageable instrumental activities. In this context, students should be encouraged to get involved in *helpful behaviors* to develop further a sense of control and mastery and, eventually, engage in more effective coping. For example, in the former Yugoslavia, children were organized into Garden Clubs that engaged in finding ways to protect their plants from being ruined when there was an enemy attack (Berk, 1998). In Israel, when schools were closed during the Gulf War, some teachers encouraged their students to keep a log of their war experiences so they could create a class magazine. In it they discussed their experiences; presented their own poems, stories, and drawings; and created humorous cartoons and situation-specific crosswords.

Anticipatory guidance. School-based anticipatory guidance includes developing plans to deal with multiple war scenarios. For example, it may involve planning for physical safety measures, engaging in simulations and drills, and establishing different communication procedures. An example of student preparation for unconventional war is illustrated by the response to the impending Gulf War by Israeli schools. From such guidance, students were (a) introduced to the possibility of missile warfare (including chemical and biological scenarios) and to the availability of protective measures against chemical fallout; (b) instructed about student behavioral expectations, especially when staying in the predesignated, confined, sealed rooms or areas; (c) introduced to a gas mask and a protective kit that included atropine (a substance used to counteract the effects of chemical warfare) and a syringe; (d) trained, in controlled gradual exposure sessions, when and how to use the gas mask and, among older children to, self-inject and; (e) psychologically debriefed. Through simulations and training (donning, learning to fasten correctly, and breathing through the gas mask), students gained a sense of competence and a sense of at least partial mastery. Older pupils were also trained in helping others to wear the gas mask. They thus could train others at home and, should war erupt, assist others in need (e.g., the very young, the very old, the handicapped). As it turned out, children and adolescents were observed to be very helpful at home during the war. In some classes students were unable to wear gas masks properly. Feeling trapped, some could not stand wearing them for a long time. Among these students, group desensitization sessions supervised by a school mental health professional were helpful.

In all classes the fear of biological and chemical attack was evident from the many questions students raised during presentations. In facilitating such discussions, teachers were advised to minimize the uncontrollable, threatening aspects of unconventional warfare and instead to stress the controllable safety measures. Older children were also provided booklets prepared by biology and chemistry teachers (with the help of school mental health professionals) explaining in detail the related chemical warfare technical terms.

Unconventional warfare is a complex issue often beyond the comprehension of younger children; direct frontal explanation and the introduction of the mask, and especially wearing it, can increase fears and raise confusion and uncertainty. Thus for the very young, story-and-coloring booklets were specially developed by school psychologists (in cooperation with kindergarten and elementary school teaching experts and artists) to help the children learn basic war-related concepts and basic safety measures and to deal with the anxiety and noncompliance associated with gas masks. One such story-and-coloring notebook (Lahad & Lahad, 1991) consists of a story that creates a psychological framework for discussion about gas masks and chemical warfare. It uses illustrations of alien-like, funny-looking space clown figures visiting a cave in which the air is polluted and thus difficult to breathe. They meet a rabbit that teaches them, through vicarious modeling, how to use a (gas) mask until the air is clean. The book includes a page on which the child can paint a gas mask. The illustrated story creates a psychological framework for discussion about gas masks and the practicalities involved in wearing them. This also enabled a gradual exposure of the young children to the impending unconventional warfare, giving information using terminology that is close to the child's world, and offered an opportunity to discuss feelings with an emphasis on coping and functioning in the event of using gas masks. A teachers' manual guides teachers on how to relate, via the illustrated story, to various war-related aspects, such as the social implications (e.g., everyone wearing the black gas mask looks alike, experiences restriction in movement, and encounters difficulties in communicating), the emotional implications, and the operational or practical implications. Another story-and-coloring book was developed to help children who show noncompliance and fear (Klingman, Ginsburg, & Markman, 1991). It made use of a child's teddy bear for which the child prepares a gas mask and deals with the teddy's anxiety. It focuses on coping statements "so that neither of them is too afraid," and was designed for use both in the anticipatory period and during wartime.[1]

Individual-Focused Interventions

Although school-based mental health professionals are less engaged in longer-term wartime individual and small group treatment, they may become involved in such. For older children, classical conditioning treatment (e.g., systematic desensitization and flooding) can be effective in treating PTSD (Saigh, Yasik, Oberfield, & Inamdar, 1999). With younger children the war-related interventions more often combine classical conditioning with selected elements of both dynamic and cognitive-behavior therapies. Some such (group and individual) clinic-based war-related interventions are summarized elsewhere (Klingman, in press). It is more common for school mental health professionals to find themselves involved in individual treatment within emergency crisis intervention. Parent-implemented treatment via consultation procedures may become practical. The use of a coercive-prescriptive consultation to parents in wartime emergency was demonstrated regarding a five-year-old Israeli child's refusal to use a gas mask during the Gulf War. The parent's difficulty with his behavior (e.g., tantrums, removing the gas mask when it was put on) was complicated by the urgency of the situation (given the high probability of chemical missile warheads). A short-term, family-focused, cognitive-behavioral intervention was the method of choice. The treatment procedure combined consultation with the parents regarding their own anxiety and response to the child, and guided them in procedures of contact desensitization and cognitive-behavioral prompts through bibliotherapy, play, and behavior modification. This case study (Klingman, 1992b) highlighted the possible role of a school psychologist as a consultant in indicated preventive intervention. The psychologist utilized the child's parents (i.e., the natural support system) in the natural setting (i.e., the home), adhering to the continuity principle, within a three-day (short-term, emergency) crisis-intervention, in the midst of a war.

Summary and Concluding Remarks

Children and adolescents must have a framework within which they can place their war experiences, assimilate them, and accommodate their life schemas to make some kind of sense out of them. In wartime, schools may be the best and, often, the only place to provide for the mental health needs of youths. In addition schools, or alternative organized learning and/or recreation settings, are important because they provide a sense of relative stability. It is a place where it is legitimate also to think of other things and get actively involved with purposeful activities to achieve success, experience self-control, and think about the future. Intervention by schools is also one of the best operationalizations of the continuity principle. However, schools are organized in terms of a stable community and thus it may be hard for them to meet the special needs of pupils and staff in emergencies. Thus, in wartime, or as soon as possible following it, reorganization and adaptation of the school system to the new demands become a priority, and assisting the school in these matters is an important role for crisis intervenors.

This chapter highlights the importance of communitywide mass communication as a means of outreach. Schools and/or alternative educational systems are the best organized or supervised delivery system, especially for resiliency promotion on behalf of a community's young people. Teachers have an advantage in reaching out to children and adolescents to promote resiliency. In addition, for those young people who receive little (or no) support at home, a relationship with an understanding adult (who can give affection and help them make sense of their experiences), often the teacher, can have a powerful protective effect.

War-related intervention should be preventive, supportive, and protect children and adolescents from secondary adversity. It aims at "normalizing" and structuring a setting so as to give students a sense of psychological and physical security, and also to support parents. This typically involves school reorganization, the adjustment of school policies, and an emphasis on group or classroom creative activities. From a prevention frame of reference, it is resiliency building that characterizes the prime task of wartime intervention. When it occurs spontaneously, resiliency should be strengthened; when it does not, it should be systematically taught.

Unlike most other disasters, war is a protracted rather than a short-duration event and often is predictable. Because war can be anticipated, it is possible to engage in preparation to help children and adolescents cope. In addition, more objective methods can be designed while planning for war-related psychological intervention, with regard to mass screening, diagnosis, and the evaluation of changes. Assessment of students' response and coping should be ongoing, continuously conducted throughout the entire intervention, and involve a long-term follow-up evaluation process.

This chapter delineated some basic issues facing school mental health professionals during wartime. The issues discussed were based largely on observations and experiences. Different types of war may necessitate different types of interventions. Moreover, beyond strategies, tools, and techniques, it is essential to rely on the professional's creativity to use all resources available.

References

Antonovsky, A. (1979). *Health, stress, and coping: New perspectives on mental health and physical well-being*. San Francisco: Jossey-Bass.

Antonovsky, A. (1980). Pathways leading to successful coping and health. In M. Rosenbaum (Ed.), *Learned resourcefulness: On coping skills, self - control, and adaptive behavior* (pp. 31-63). New York: Springer.

Babad, E. Y., & Salomon, G. (1978). Professional dilemmas of the psychologist in an organizational emergency. *American Psychologist*, *33*, 840-846.

Ben-David, A., & Lavee, Y. (1992). Families in the sealed room: Interaction patterns of Israeli families during SCUD Missile attacks. *Family Process*, *31*, 35-44.

Berk, J. H. (1998). Trauma and resilience during war: A look at the children and humanitarian aid workers of Bosnia. *Psychoanalytic Review*, 85, 639-658.

Bloom, J. W., & Walz, G. R. (Eds.). (2000). *Cybercounseling and cyberlearning: Strategies and resources for the millennium*. Alexandria, VA: American Counseling Association.

Breznitz, S. (1983). *Stress in Israel*. New York: van Nostrand Reinhold.

Brackman, P., & Petty, C. (1998). *Rethinking the trauma of war*. New York: Free Association Books.

Brock, S. E. (2002). Group crisis intervention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (pp. 385-404). Bethesda, MD: National Association of School Psychologists.

Bronfman, E. T., Campis, L. B., & Koocher, G. P. (1998). Helping children to cope: Clinical issues for acutely injured and medically traumatized children. *Professional Psychology: Research and Practice*, 29, 574-581.

Byers, J. G. (1996). Children of the stones: Art therapy intervention in the West Bank. *Art Therapy*, *13*, 238-243.

Caplan, G. (1976). *Support systems and community mental health*. New York: Behavioral Sciences.

Duncum, P. (2000). How art education can contribute to the globalization of culture. *Journal of Art and Design Education*, *19*, 170-180.

Durlak, J. A. (1998). Common risk and protective factors in successful prevention programs. *American Journal of Orthopsychiatry*, 68, 512-520.

Gal, R. (1998). Colleagues in distress: Helping the helpers. *International Review of Psychiatry*, *10*, 234-238.

Garbarino, J., & Kostelny, K. (1993). Children's response to war: What do we know? In L. A. Leavitt & N. A. Fox (Eds.), *The psychological effects of war and violence on children* (pp. 23-39). Hillsdale, NJ: Lawrence Erlbaum Associates.

Garmezy, N. (1985). Stress resistant children: The search for protective factors. In J. E. Stevenson (Ed.), *Recent research in developmental psychopathology* (pp. 213-223). Oxford, UK: Pergamon Press.

Gutkin, T. B. (1999). Collaborative versus directive/prescriptive/expert school-based consultation: Reviewing and resolving a false dichotomy. *Journal of School Psychology*, *37*, 161-190.

Higgins, G. O. (1994). *Resilient adults: Overcoming a cruel past*. San Francisco: Jossey-Bass.

Hobfoll, S. E., Spielberger, C. D., Breznitz, S., Figley, C., Folkman, S., Lepper-Green, B., Meichenbaum, D., Milgram, N. A., Sandler, I., Sarason, I., & van der Kolk, B. (1991). War-related stress. *American Psychologist*, *46*, 848-855.

I dream of peace. (1995). New York: Unicef-Collins Pub.

Jacobs, S., & Prigerson, H. (2000). Psychotherapy of traumatic grief: A review of evidence for psychotherapeutic treatment. *Death Studies*, *24*, 479-495.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.

Jones, C., & Rutter, J. (1998). *Refugee education: Mapping the field*. Staffordshire, UK: Trentham Books.

Klingman, A. (1985). Free writing: Evaluation of preventive program with elementary school children. *Journal of School Psychology*, *23*, 167-175.

Klingman, A. (1992a). School psychology services: Community-based first order crisis intervention during the Gulf War. *Psychology in the Schools*, *29*, 376-383.

Klingman, A. (1992b). The effect of parent-implemented crisis intervention: A real-life emergency involving a child's refusal to use a gas mask. *Journal of Clinical Child Psychology*, *21*, 70-75.

Klingman, A. (2000a). Prevention of anxiety disorders: The case of post-traumatic stress disorder. In W. K. Silverman & P. A. D. Treffers (Eds.), *Anxiety disorders in children and adolescents: Research, assessment, and intervention* (pp. 368-391). Cambridge, UK: Cambridge University Press.

Klingman, A. (2000b). Stress responses in Israeli school-age students evacuated from homes during massive missile attacks. *Stress, Anxiety, and Coping*, *14*, 1-24..

Klingman, A. (in press). Children under war stress. In A. La Greca, W .K. Silverman, E. Vernberg, & M. C. Roberts (Eds.), *Helping children in disasters: Integrating research and practices*. Washington, DC: APA Books.

Klingman, A., Ginsburg, I., & Markman, D. (1991). *Dubico's gas mask*. Jerusalem: The Counseling and Psychological Service of the Ministry of Education, and the Counseling Division, Department of Education, University of Haifa (In Hebrew).

Krkeljic, L., & Pavlicic, N. (1998). School project in Montenegro. In O. Ayalon, M. Lahad, & A. Cohen (Eds.), *Community stress prevention* (Vol. 3, pp. 51-61). Jerusalem: Shefi – The Psychological and Counseling Service of the Israeli Ministry of Education.

Kubovi, D. (1974). The application of therapeutic teaching methods in an emergency situation. *Studies in Education*, *2*, 167-174. (In Hebrew).

Lahad, M., & Lahad, M. (1991). *The Latzkanim in search of a gas mask*. Haifa: Nord. (In Hebrew).

Lahad, S., Shacham, Y., & Niv, S. (2000). Coping and community resources in children facing disaster. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 389-395). New York: Kluwer Academic/Plenum.

Lazarus, A. A. (1976). *Multimodal behavior therapy*. New York: Springer.

Lazarus, A. A. (1989). *The practice of multimodal therapy: Systematic, comprehensive and effective psychotherapy*. Baltimore: Johns Hopkins University Press.

Macksoud, M. S., Haber, J. L., & Cohn, I. (1996). Assessing the impact of war on children. In R. J. Apfel & B. Simon (Eds.), *Minefields in their hearts: The mental health of children in war and communal violence* (pp. 218-230). New Haven: Yale University Press.

Marzek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for prevention research*. Washington, DC: National Academy Press.

McFarlane, A. C. (2000). Posttraumatic stress disorder: A model of the longitudinal course and the role of risk factors. *Journal of Clinical Psychiatry*, 6 (Suppl. 5), 15-20.

Mitchell, J. T., & Everly, G. (1996). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers*. Ellicott City, MD: Chevron Publishing.

Muldoon, O., & Cairns, E. (1999). Children, young people, and war: Learning to cope. In E. Frydenberg (Ed.), *Learning to cope: Developing as a person in complex societies* (pp. 322-337). Oxford, UK: Oxford University Press.

Neria, Y., & Solomon, Z. (1999). Prevention of posttraumatic reactions: Debriefing and frontline treatment. In P. A. Saigh & J. D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive text* (pp. 309-326). Boston: Allyn & Bacon.

Noy, B. (1992). The open line for students in the Gulf War. *School Psychology International*, *13*, 207-227.

Omer, H., & Alon, N. (1994). The continuity principle: A unified approach to disaster and trauma. *American Journal of Community Psychology*, *22*, 273-283.

Paardekooper, B. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology and Psychiatry*, *40*, 529-536.

Pennebaker, J. W. (1993). Putting stress into words: Health, linguistics and therapy. *Behavior Research and Therapy*, *31*, 539-548.

Perrin, S., Smith, P., & Yule, W. (2000). Practitioner review: The assessment and treatment of post-traumatic stress disorder in children and adolescents. *Journal of Child Psychology and Psychiatry*, *41*, 277-289.

Phillips, D., Linington, L., & Penman, D. (1999). *Writing well: Creative writing and mental health*. London, UK: Jessica Kingsley Publishers.

Raviv, A. (1993). The use of hotline and media interventions in Israel during the Gulf War. In L. A. Leavitt & N. A. Fox (Eds.), *The psychological effects of war and violence on children* (pp. 319-337). Hillsdale, NJ: Lawrence Erlbaum Associates.

Reynolds, M., Brewin, C. R., & Saxton, M. (2000). Emotional disclosure in school children. *Journal of Child Psychology and Psychiatry*, *41*, 151-159.

Robson, D., & Robson, M. (1998). Intimacy and computer communication. *British Journal of Guidance and Counseling*, *26*, 33-41.

Sabljak, L. (1999). How librarians help children overcome the consequences of war in Croatia. In O. Ayalon, M. Lahad, & A. Cohen (Eds.), *Community stress prevention* (Vol. 4, pp. 34-40). Jerusalem: Shefi - The Psychological and Counseling Service of the Ministry of Education.

Saigh, P. A., Yasik, A. E., Oberfield, R. A., & Inamdar, S. C. (1999). Behavioral treatment of child-adolescent posttraumatic stress disorder. In P. A. Saigh & J. D. Bremmer (Eds.), *Posttraumatic stress disorder: A comprehensive text* (pp.354-375). Boston: Allyn & Bacon.

Sandoval, J., & Lewis, S. (2002). Cultural considerations in crisis intervention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (pp. 293-308). Bethesda, MD: National Association of School Psychologists.

Schwarcz, J. H. (1982). Guiding children's creative expression in the stress of war. In C. D. Spielberger, I. G. Sarason, & N. A. Milgram (Eds.), *Stress and anxiety* (Vol.8, pp. 351-354). Washington, DC: Hemisphere.

Shilo-Cohen, N. (1993). Israeli children paint war. In L. A. Leavitt & N. A. Fox (Eds.), *The psychological effects of war and violence on children* (pp. 93-107). Hillsdale, NJ: Lawrence Erlbaum Associates.

Solomon, Z. (1995). *Coping with war related stress: The Gulf War and the Israeli response*. New York: Plenum.

Stone, B. A. (1998). Self-body-image and PTSD in Australia Spanish speaking trauma survivors. In A. R. Hiscox & A. C. Calsich (Eds.), *Tapestry of cultural issues in art therapy* (pp. 176-198). London: Jessica Kingsley Publishers.

Turkel, S. (1995). *Life on the screen: Identity in the age of the Internet*. London: Phoenix.

Yule, W. (1998). Posttraumatic stress disorder in children and its treatment. In T. W. Miller (Ed), *Children of trauma: Stressful life events and their effects on children and adolescents* (pp. 219-243). Madison, CT: International Universities Press.

Yanoov, B. (1976). Short-term intervention: A model of emergency services for times of crisis. *Mental Health and Society*, 3, 33-52.

Zotovic, M. (1998). Their point of view. In O. Ayalon, M. Lahad, & A. Cohen (Eds.), *Community Stress Prevention* (Vol. 3, pp. 24-31). Jerusalem: Shefi - the Psychological and Counseling Service of the Israeli Ministry of Education.

Endnote

[1] For discussion of the use of this booklet as a part of indicated intervention for treating noncompliance during the Gulf War, see Klingman, 1992a.

29

Traumatized Refugee Children

危機

Patricia del Valle, Ph.D.
Florida International University

At a special early morning meeting at Citrus Grove Elementary School in Miami, Florida, the school psychologist is frantically greeted by the school administrator. She says, "I am glad to see you. Forty-eight Cuban refugee children arrived on rafts this week and are registered here." She explains that the children range in age from 5 to 11 years. All experienced a life-threatening escape from Cuba and a treacherous crossing to the United States. Some reported witnessing a child drowning and being eaten by a shark. The children do not speak English, do not understand the American culture, and are unaware of appropriate behaviors and expectations in their new American school. She concludes with an urgent query, "What do we do?"

Refugees are considered to be involuntary migrants forced to flee their homeland. Reasons for fleeing include impending threat of violence, injury, or death caused by political, economic, social, religious, or natural disasters. Refugee children are considered vulnerable to the effects of migration (Guarnaccia & Lopez, 1998). This vulnerability partially stems from their status as children, which involves dependence on others, usually their parents, who decide to migrate. The refugee child's level of cognitive development and lack of knowledge contribute to the challenges he or she may experience in understanding the changes associated by migration. In addition, refugee youths typically lack the necessary material resources to get established in their new homeland. However, young refugees may also be protected from some negative effects of the migration because of their flexibility, ability to learn a new language, and naivete.

The number of refugee children in schools throughout the world continues to increase. Currently, there are approximately 23 million reported refugees in the world (United Nations High Commissioner for Refugees, 1996), of which half are children. These refugee children offer new challenges to school personnel and crisis workers in providing educational and psychological services.

The refugee experience reflects great diversity in conditions, ranging from the relatively benign, such as flying first-class on a commercial airline to a luxury residence in Miami for political or religious migration with intact families, to the horrible and traumatizing experience of escaping genocide, mass destruction, and the loss of community and family, such as in Cambodia, Bosnia, or Tibet. The literature addresses the stressors associated with refugee migration (Aronowitz, 1984; Esquivel & Keitel, 1990; Hovey & King, 1996; Hulewat, 1996; Gonslaves, 1992). However, not all youth or groups migrate under similar circumstances, nor do people migrating under similar conditions experience the same levels of distress or trauma.

This chapter provides information for understanding the experience of many refugee children, adolescents, and families. This chapter highlights unique issues, such as the refugee experience and resettlement stages, psychological adjustment of refugee children, developmental issues, cultural issues and acculturation stress, preparing for crisis management with refugee students, and school-based interventions for refugee children. It also offers general suggestions for working with traumatized refugees in the school setting.

Unique Crisis Issues: The Refugee Experience and Resettlement Stages

For traumatized refugee youth the refugee experience and resettlement are often life crises. Whether the refugee children are from Europe, Africa, the Far East, or Central America, they leave behind all that is well-known to them and all that has shaped their sense of self (e.g., food, clothing, books, toys, friends, pets, and family members). Falicov (1998) eloquently describes this experience:

> Physical uprooting entails living without the familiarity of people's faces and the sound of their voices; without the feel of the streets and the comfort of the houses, without the odors of foods, the myriad of smells, sounds, and sights, the cold and heat of the air, without the color of the sun, or the configuration of stars in the night sky. The landscape that had been internal as well as external—a very part of the immigrant's soul is gone. (p. 52).

The migration stressors and effects on refugee youth need to be understood from a dynamic interaction of many factors (Guarnaccia, 1997; Hulewat, 1996). The most salient stressors are likely to be the physical and psychological traumatic experiences encountered in the homeland. These refugee children may have witnessed or experienced war, political and social unrest, torture, disappearance or death of family members or friends, forced labor, or environmental disaster (Howard & Hodes, 2000). Living with the fear of anticipated violence, torture, and loss motivates many families to seek a "strange" but "safe" haven, often risking death (e.g., rafters from Cuba and boat people from Haiti). Usually, this means forfeiting one's status, possessions, and social support. Moreover, traumatized youths may also suffer from the loss of their parents through disappearance, detainment, or death in the homeland.

Refugees are diverse in terms of their national origins and languages, as well as economic, social, and cultural factors. However, the common thread of sharing experiences such as preimmigration, migration, and resettlement unites them (Hulewat, 1996). Sluzki (1979) noted a definite progression of five resettlement stages: (a) preimmigration or preparatory, (b) migration, (c) arrival, (d) decompensation, and (e) transgeneration. Each stage has implications for assessment and crisis intervention work with refugee children in schools. It is important for mental health providers to understand each stage and assess the status of the refugee children and parent(s) or guardian(s).

Preimmigration or Preparatory Stage

Most refugees are overwhelmed by political, social, religious, economic, or natural events, which are frequently out of their control before they flee their homeland. Many have experienced events such as life threats, imprisonment, torture, war, disappearance or death of family members or friends, school closings, religious persecution, curfews, or confinement to home or shelters. Hence, refugees experience migration stressors before the actual migration. Children may be excluded from the preparatory stage and may become anxious as daily activities and parents are secretive or stressed. For example, youths may see or experience the selling of household belongings, frequent talks behind closed doors, or a sudden, unplanned journey in the middle of the night (Gonslaves, 1992). Such events may affect the child in numerous ways. After these children arrive in the new host country, the crisis intervenor needs to assess the trauma experienced or witnessed in the homeland.

Migration Stage

Migration is unique for each refugee population, family, and child. Some refugees endure shark-infested, turbulent waters on homemade rafts or boats; others are smuggled on cargo boats or run across unknown borders during the night. The more fortunate families travel by commercial or private ships, planes, or trains. Upon arrival many families are placed in refugee or detention camps where crowded living conditions usually exacerbate their distress, despair, and hopelessness (e.g., Guantanamo Naval Base in Cuba, Krome Detention Center in Miami, Florida, or Casa Romero in Texas). When long-term detention occurs, depression and suicidal ideation are common. Carlin (1979) reported assault and torture in refugee camps in Southeast Asia, which produced traumatized children who had symptoms of posttraumatic stress disorder (PTSD) such as psychic numbing, anxiety, and recurring nightmares.

Refugee migration is a major life event that challenges adaptive capacity as well as the entire family system. Kunz (1972) posited that the flight phase was a predictor of the intensity, duration, and the number of psychological traumas and resettlement problems experienced in the new homeland. Crisis intervenors must understand how an uprooting experience can affect the refugee in the arrival process, which is often associated with painful and intrusive memories.

Related to this stage, the crisis intervenor needs to assess the child's separation from attachment figures, including parent(s) or guardian(s), siblings, extended family, and friends. Unaccompanied youngsters who leave without their parents, guardians, or relatives pose the highest risk for serious psychological impairment (Looney, 1979). It is critical to assess the number of separations as well as the child's age and developmental level at the time of separation. Other factors affecting the adjustment of refugee children include the context of their arrival, economic situation, birth country, and rural or urban origin (Canino & Spurlock, 2000).

In 1994 I worked with Cuban rafter children in Miami who drew pictures of pirate flags on small rafts, people being eaten by sharks, children drowning in the turbulent waters, and armed Cuban patrol boats. The children reported that leaving their homeland was an illegal act punishable by death. During this stage, the children may believe that their stay in the host country is only temporary. This may be a short-term, healthy way of coping with a transitory crisis—the migration. As one Haitian refugee child told me: "I am on vacation in America until my country is fixed."

Arrival Stage

Arrival in the new homeland can be an exhilarating, exhausting, optimistic, and relief-filled experience for some refugees; for others, arrival can be a disorienting, sad, angry, and guilt-ridden experience. The resettlement community plays a critical role in the refugees' adaptation process. Factors that relate to adaptation include: (a) the community's economy; (b) the refugee's legal status; (c) the number of relatives in the community; (d) housing conditions of the family in the community; (e) the number of children, friends, and classmates that arrive together; (f) institutional support available for incoming refugees; and (g) the age of the child upon arrival (Gonslaves, 1992). The parents' or guardians' education, income, and employment status also contribute to the adaptation process.

At this stage, the crisis intervenor can help the refugees connect to agencies that provide economic, medical, and social support. The goal during this stage is to help build a transition bridge for the refugees from their homeland to the new host country. The American Red Cross, Catholic Relief Fund, United Nations Development Program (UNDP), United Nations High Commissioner for Refugees (UNHCR), and the United Nations Children's Fund (UNICEF) agencies can reach out to refugees and aid in their adaptation. Agencies can help refugee children learn about the new school and community and meet fellow refugee children; supply immediate medical attention; provide housing and food; provide bilingual/bicultural services and interpreters when available; and help refugees enroll in language classes.

Decompensation Stage

During this stage the family and/or child frequently begin to realize and experience the complete impact of their losses. Refugees often struggle to integrate their previous cultural experiences into their new life. Refugees may doubt their ability to "make it" in their new homeland and may become vulnerable to the psychological impact of old memories. They are likely to miss their family members, school, neighborhood, friends, pets, and toys, and often demonstrate extreme nostalgia (Zwingmann, 1973).

Psychological symptoms experienced during this stage may include apathy, anxiety, depression, eating and sleeping difficulties, somatic complaints, and fears (Hubbard, Realmuto, Northwood, & Masten, 1995; McKelvey & Webb, 1996; O'Shea, Hodes, Down, & Bramley, 2000; Sack, 1998). For example, one Nicaraguan eight-year-old girl resettled in Miami drew her sadness as a "heartache." Another refugee child in Miami played guerilla war with toy soldiers; he reported being "nerviosa"(nervous), very sad, unable to sleep, and worried about his father and brother who remained in El Salvador. An unaccompanied Nicaraguan adolescent, who arrived in Miami after asylum in Texas, tearfully shared she was very "triste"(sad) and could not sleep because she had recurring nightmares about the "coyotes" (paid smugglers who helped her cross the U.S.-Mexico border). She remembered running across the land "for her life" and seeing the bodies of dead people. Even though this stage is termed "decompensation," serious decompensation, which may necessitate psychiatric intervention, is rare. Gonslaves (1992) proposed four major issues accounting for refugee collapse: (a) personal adaptation failure, (b) disintegration of the family system, (c) environmental isolation, and (d) existential crises. Sluzki (1979) warned against stigmatizing "overwhelmed" refugees. In most cases, though the refugees become overwhelmed, they do not require hospitalization or intensive psychiatric intervention.

In the decompensation stage, the crisis intervenor may want to assess the current family atmosphere, including family cohesion and conflict, social networks to include members from the homeland and the host country, acculturation/adaptive levels, feelings of marginality and oppression, coping strategies, academic stress, pre- and postmigration stress, caregiver's parenting effectiveness, and caregiver's emotional availability. During this stage, psychological issues may reemerge. The crisis intervenor must recognize the tremendous strain placed on the refugee to learn a new culture and must understand that multiple losses may not yet have been recognized and worked through at this time. Behavioral and emotional changes in the refugee youth, such as risk-taking, acting out, and survivor guilt, also may need monitoring.

Transgeneration Stage

This stage involves passing on to the following generations any unresolved conflicts stemming from the refugee experience and migration. Even though refugee children may be in a safer environment, they have to deal with and work through multiple losses produced by exile, acculturative stress, and adaptation. The refugee experience and resettlement may create increased separation between parents and children. Parents may be forced to work several jobs to survive and may not be available for their children. Moreover, children often acculturate faster and easier, which can lead to intergenerational conflict. In turn, parents may strengthen family values and tradition to protect family integrity and provide continuity and stability (Strier, 1996).

The crisis intervenor may want to assess the different acculturation levels within the family, the ethnic identity of each refugee youth, and the cultural values and belief systems of each child. More family interventions as well as individual strategies are usually required during this stage because the refugees are dealing with psychological adaptation rather than survival. For instance, parents may not want their children to lose their native language and customs. Family disappointments stemming from the children's acculturation may lead to family conflict and parental and adolescent depression (Guarnaccia & Lopez, 1998; Gil & Vega, 1996).

Psychological Adjustment of Refugee Children

A few scientific studies have looked at the psychological adjustment of refugee children (Aronowitz, 1984; Esquivel & Keitel, 1990; Hovey & King, 1996; Hulewat, 1996; Gonslaves, 1992). Refugee children do not necessarily develop psychological problems; however, some may experience high distress levels as well as psychiatric disorders resulting from their adverse experiences (Hubbard et al., 1995; Sack, 1998; Weine et al., 1995). A wide range of psychological symptoms was reported for those who were adversely impacted. Depression, PTSD, and anxiety were especially prevalent. In addition, refugee children may exhibit suicidal behavior, sleeping difficulties, somatic complaints, learning problems, or antisocial conduct (Arroyo & Eth, 1985).

Developmental Issues

Children and adolescents may experience various stressors and effects depending on their developmental levels of functioning. Young refugee children typically exhibit challenging behaviors, while refugees who arrive as adolescents often present with identity issues (del Valle, McEachern, & Sabina, 1999). For example, a young child may present as overanxious with clinging behavior and may feel confused, frightened, and overwhelmed (Stronach-Bruschel, 1990). Adolescents, who are in the normal process of developing more independent identities, are further confused by the difficulty of being submerged in a new culture (Guarnaccia & Lopez, 1998). Despite the growing literature on the effects of immigration on refugee youth, the role of gender in refugee experiences has been neglected. In one of the few studies examining gender effects, Huyuck and Fields (1981) found that parent-child separations lead to greater psychological risk, especially for boys aged 6 to 11.

Cultural Issues and Acculturative Stress

Perceived cultural differences between the home and host culture may affect acculturation outcomes of these children. For example, gender role expectations may add to the intergenerational conflict. The male/female roles and expectations differ considerably from culture to culture. Most Western European nations offer females more equality, freedom, and flexibility than non-Western nations. The gender role difference often causes tension among adolescent refugees and their traditional adult family members. Other examples of differences between home and host cultures may center around such issues as which language the child should speak at home; what career choice is best for the adolescent; or how traditional parental expectations about the youth's friends, dating, clothing, and curfew are resolved.

Crisis intervenor must be able to distinguish symptoms related to resettlement difficulties from PTSD (Rousseau, Drapeau, & Corin, 1996). Children with PSTD require more intensive psychological services. In addition, the psychological distress in the refugee child must be repeatedly assessed to examine the child's acculturative stress. Acculturative stress occurs from the difficulties encountered when the refugee child attempts to adapt from the original culture and family systems to those of the new host country. Acculturation may involve changes in behavior, values, self-identity, and attitudes (Williams & Berry, 1991).

Language difficulties or an inadequate academic background of refugee children often contribute to their acculturative stress. Distress will be increased if children and their family do not know or have difficulties with the host language. Language difficulties contribute to academic problems, such as lower levels of academic achievement, especially in reading and language arts (Cumins, 1982). Furthermore, lack of proficiency in the new host language may affect social competence in the community. Children who are unable to communicate find it harder to make friends and to participate in team activities and organizations (Taft, 1979). The acquisition of a new language is especially problematic for youths who had limited formal education in their homeland. These problems frequently cause refugee children to experience academic failure, increased frustration, and low self-esteem (Esquivel & Keitel, 1990). Another variable adding to acculturative stress in children is the perceived discrimination against the refugee group because of such factors as language, skin color, other physical characteristics, clothing, food, and customs. For example, I have found that many Haitian refugee youths deny they speak Haitian/Creole, because this language connotes a lesser status than does French.

Acceptance by the existing ethnic enclave may be critical to the adjustment of the new refugee youth. McKelvey and Webb (1996) investigated Vietnamese-Amerasians support expectations from their preimmigration community and their American Vietnamese arrival community. Those refugee children with higher U.S. Vietnamese support aspirations had the highest depressive symptoms when assessed several months later. This study showed that aspiration levels and their consistency with reality affect the adjustment of such refugees.

Crisis Prevention in the School Setting

School crisis prevention related to refugee students requires a team approach. The refugee experience may result in short- or long-term psychological distress. Preventive interventions may target the refugee subgroup and identify individual youngsters who are displaying psychological distress. School personnel can help by teaching appropriate coping skills, building a strong supportive relationship with parent(s) or guardian(s), and fostering a positive school-home partnership.

Developing a School Support Team

Forming an ad hoc school team composed of an administrator, school psychologist, counselor, social worker, school nurse, and the teachers of the refugee children is recommended. The team should meet on a regular basis. Areas to address may include: (a) assessing the difficulties and problems faced by the refugee students, their families, and the school staff; (b) identifying student and school strengths and resources; (c) designing adaptation/acculturation programs for the school and home; (d) developing individually tailored interventions for specific students; and (e) evaluating the results of any intervention.

Administrative Support

Administrative support is necessary to integrate the refugee students and their families into new schools and communities. Some school staff will be more engaged in this process than others. For example, crisis intervenors, including school psychologists, counselors, social workers, and nurses, may be providing short-term interventions with this population. Hence, modifications in job duties may occur during this time (e.g., the teacher of refugee children may be expected to postpone a daily lesson so a class discussion or a group activity can occur). In addition, physical space and privacy is needed to work with the refugee students. Translators may also need to be hired and trained to facilitate communication among the refugee students, their families, and the school staff.

Training School Personnel

Offering training to the entire school staff may be necessary depending on the number of refugee students. This training will enable any staff member who has contact with the refugee students to understand the refugee experience, provide necessary support, and link the student to a helping resource. Often, school staff and students may not have knowledge, understanding, or skills related to the specific culture of the refugee students. Training needs to be offered that explains the students' culture, values, belief systems, and worldview. An effort needs to be made to develop awareness and sensitivity of the staff. It is essential to teach school staff and students about the effects of trauma, typical reactions, and the identification of psychological stress. Consultation to assist teachers to develop innovative strategies and help promote refugee coping and adaptation is recommended. In addition, it is important for the team to work with the previously enrolled students to help them understand the refugee children and their culture. An activity that may be used to teach the host students about the newcomers' culture is to sponsor a cultural week in the school. This cultural week allows the sharing of such elements as art, music, history, dance, and food from the refugee students' cultural backgrounds. The refugees may choose to give presentations about their homeland and culture at school assemblies, or on the school radio or television.

Hiring Interpreters and Consultants

The need for interpreters may occur when the refugees are not proficient in the host language and where there are few multilingual/multicultural crisis intervenors (O'Shea et al., 2000). The interpreters may assist in interviewing and communicating. Figueroa, Sandoval, and Merino (1984) recommend that interpreters be trained in: (a) establishing rapport, (b) preventing information from getting lost in the interpretation process, (c) understanding how nonverbal communication supplants the interpretation, and (d) maintaining confidentiality. In addition, cultural consultants and individuals in the community who know the specific culture, such as priests, folk healers, and social workers, may serve as valuable resources to explain the culture to crisis interventionists and to communicate with refugees (Guarnaccia & Lopez, 1998).

Collaboration, Consultation, and Advocacy

Collaboration and consultation with school staff, parent(s) or guardian(s), and community agencies are needed to meet the complex needs of refugee students and their families. The crisis intervenor needs to collaborate and consult with administrators, teachers, and school staff to secure therapeutic support and resources for students and families. Refugees may need such services as free meals, housing, medical services, legal aid, job training and placement, language classes, access to social services, and mentors.

The crisis intervenor may serve as an advocate for these children in schools. Often, the advocacy role involves promoting, respecting, and valuing cultural diversity. It may also include advocacy to dispel prejudice against the recent arrivals and may entail revisiting school policies and services related to job roles, staff allocation, and the use of physical space (del Valle, McEachern, & Sabina, 1999).

Support for Crisis Intervenors and School Personnel

Weekly support groups for the crisis intervenors and school personnel offer necessary support for the caregivers to reduce stress. Crisis intervenors and school personnel need an opportunity to share and process their experiences, feelings, and thoughts about any unusual and intense interactions. These groups may also address the stress and fatigue involved in caring for traumatized youth (Figley, 1995).

Conducting a Needs Assessment

It is helpful to conduct a needs assessment with the refugee students, their parent(s) or guardian(s), and teacher(s). The needs assessment will help the crisis intervenor determine the type and severity of the difficulties refugee children and their families face. Specific needs and issues may be identified immediately for targeted interventions. The assessment should be conducted in the native language of the individual being assessed. If this is not possible, a trained interpreter may be used.

Assessing for Learning and Emotional Problems

Assessment tools to diagnose learning and emotional problems in traumatized youths may include formal and informal approaches. Evaluation of receptive and expressive language in the refugee child's native language is important. If the child speaks the host language, it is also necessary to conduct a thorough assessment of his or her language proficiency. Reading, written language, mathematics, and content areas should be included in the evaluation. Many standardized, structured and unstructured tools are available; however, it may be necessary to use a trained translator for those languages for which no assessment tools are available. Informal methods of language assessment may include (a) language samples of the refugee child; (b) performance and portfolio assessments; (c) teacher-made tests; and (d) observation of the child's interactions with fellow refugee peers, nonrefugee peers, adult refugees, and adult nonrefugees (Sax, 1997). Understanding the behavioral effects of second language acquisition should also be taken into consideration.

Interviews with the individual children and their parent(s) or guardian(s) may provide helpful clinical information about (a) preimmigration history and experiences; (b) adjustment problems; (c) family relationships; (d) ethnic identity issues (e.g., minority status); (e) family's acculturation level; and (f) attitudes regarding school, culture, values, and expectations. It also may be necessary to conduct an in-depth evaluation to rule in or rule out PTSD. A number of diagnostic clinical interviews, both structured and unstructured, have been developed for this purpose. (See Chapter 30, Diagnosing Child-Adolescent Posttraumatic Stress Disorder, in this volume.)

Crisis Intervention in the School Setting

Expressive Art

Expressive art may be used to help refugee children express feelings, issues, and memories that they may not entirely understand and that may be too difficult and/or painful to verbalize (Kellogg & Volker, 1993). Expressive art can facilitate communication despite language barriers, culture, repressed memories, and resistance. In addition, expressive art may help encourage self-expression and disclosure without the child feeling overwhelmed and may help the child understand and work through his or her feelings, issues, and concerns. For example, refugees may draw pictures of their migration, flags of their homeland and their new host country, their homeland school and their new school, their family in their homeland and their family in the host country, or they may illustrate a book about their journey. Moreover, through expressive arts the child produces an end product, which allows for the emergence of mastery and competence (Nickerson, 1983).

Expressive Writing

Expressive writing, like expressive art, can be a vehicle for cartharsis and for dealing with painful and traumatic memories. Pennebaker (1993) found that writing about stressful situations had psychological benefits. Using creative writing or poetry can often help children express themselves by providing an outlet other than talking. They can write letters to their family and friends who remained in their homeland or to those they have lost (Orton, 1996). For example, Cuban refugee students were eager to write about their pre- and postmigration experiences, refugee experiences, fears and worries as well as positive memories and hopes for the future (del Valle, McEachern, & Sabina, 1999). For children who have undergone migration experiences, expressive writing can aid the healing process and promote personal growth.

Bibliotherapy

Bibliotherapy involves reading and discussing texts related to the current situation and problems. The refugee children may have difficulty verbalizing their thoughts and feelings. With this intervention, the refugee students may deal with their difficulties, traumas, and stressors from an emotional distance. This intervention involves identifying with a story character, projecting the student's feelings and thoughts upon the story character, and experiencing cartharsis and self-reflection (Thomas & Rudolph, 1996). Directed reading can facilitate expression of the child's feelings or problem-solving techniques. With bibliotherapy, discussions may focus around the story character's behaviors, thoughts and feelings, or on the refugees' experiences, stressors, coping mechanisms, and support systems.

Transition Crisis Group Counseling

Transition crisis groups can reduce psychological risk and maximize wellness of refugee students (Cardenas, Taylor, & Adelman, 1993). The group serves to facilitate adaptation/acculturation, reduce stress, teach coping skills, and foster bicultural development. These groups are especially important because the transition period into the new host country and school is a time of great risk for these newcomers. Additionally, these groups provide the clinician with ongoing diagnostic assessment and allow identification of students needing more intensive mental health or educational interventions.

Play Therapy

Play therapy as a sole treatment method or in combination with other methods can be a successful intervention with traumatized children (Arroyo & Eth, 1985; Eth & Pynoos, 1985; Gardner, 1993; Thomas & Rudolph, 1996; Webb, 1991). Terr (1990) described an approach to working with the child's posttraumatic play. She suggested that therapeutically reconstructing the event(s) and interpreting the child's spontaneous play can undo painful memories and helplessness and can lead to a feeling of mastery and control. The play sessions may include activities such as drawing, storytelling, and playing games.

Conclusion

To date, we lack the desirable level of research and knowledge about school adjustment and mental health issues affecting refugee children (Aronowitz, 1984; Guarnaccia & Lopez, 1998). As described in this chapter, there are some tentative findings that are helpful in guiding our work with refugee children. All refugee children do not suffer from impaired mental health. Special subgroups appear to be at higher risk for psychological difficulties. Refugee children who have experienced severe traumas or witnessed violence, whose families are socially disadvantaged, who are unaccompanied in migration and resettlement, and who have poor school performance seem to be at greater risk for mental health problems (Guarnaccia & Lopez, 1998).

The attitude of the host community and larger society also impacts the well-being of these children. Acceptance and tolerance contribute to the adaptation and acculturation of refugee youth. The schools offer a critical context for the adaptation, acculturation, and biculturation of these youngsters. Schools should conduct a needs assessment and early interventions for refugee children in order to prevent more serious psychological impairment. Schools also should provide instruction to facilitate the acquisition of the new language, which will impact their academic performance. Most refugee youth need assistance and support to adapt, develop, and thrive in their new homeland. The schools function as a critical stabilizer for dislocated, disoriented, and traumatized children who may have difficulty learning in the traditional school environment of their new homeland. Thus, the school serves as the central hub, providing mental health and social services such as housing, food, medical services, language instruction, job training and placement, and counseling for the families.

Because of the increasing number of refugee children and families around the world, schools will continue to face the multiple challenges of working with this population. Therefore, as professionals in the mental health and education fields, we have a responsibility to continue to explore the issues, circumstances, and implications surrounding the development of refugee children. Directions for future research include: (a) developing accurate assessment procedures and tools; (b) promoting in-depth exploration of trauma, posttraumatic stress, and psychological impairments associated with refugee children and youth; (c) understanding the characteristics, behaviors, and circumstances of nontraumatized refugee children and youth; (d) improving multicultural and crisis intervention training for school personnel; (d) designing effective, research-based individual and group counseling interventions; (f) implementing creative, nontraditional teaching strategies and mental health interventions for refugee children; and (g) creating and evaluating programs for adaptation, acculturation, and biculturation for refugee children and families. It is important to take steps to review and improve current political, social, and educational policies, procedures, and services available to refugee children and their families.

This chapter has focused on refugee experiences, including the effects of uprooting, migration, and resettlement. To assist crisis intervenors and school personnel in assessment and treatment, I have presented a number of important factors that impact refugee adaptation and acculturation. Follow-up evaluations are necessary to monitor the refugees' progress and to identify their emerging needs. In addition, it is important that crisis intervenors be open and willing to explore their own values and worldview.

Capable staff may work with refugee children to diagnose and ameliorate problems, gain the trust of refugee children and families, and help to restore faith and hope to these vulnerable children. Developing school-based interventions is crucial to educating these youths whether they return to their homeland, resettle in another country, or remain in their new host country. Schools that are committed to developing and sustaining comprehensive programs for refugee children offer the best chance for promoting their survival and success.

References

Aronowitz, M. (1984). The special and emotional adjustment of immigrant children: A review of the literature. *International Migration Review, 18*, 237-257.

Arroyo, W., & Eth, S. (1985). Children traumatized by Central American warfare. In S. Eth & R. Pynoos (Eds.), *Children* (pp. 101-120). Washington, DC: American Psychiatric Press.

Canino, I. A., & Spurlock, J. (2000). *Culturally diverse children and adolescents: Assessment, prognosis, and treatment* (2nd ed.). New York: Guilford Press.

Cardenas, J., Taylor, L., & Adelman, H. S. (1993). Transition support for immigrant students. *Journal of Multicultural Counseling and Development, 21*, 203-210.

Carlin, J. E. (1979). The catastrophically uprooted child: Southeast Asian refugee children. In J. D. Noshpitz (Ed.), *Basic handbook of child psychiatry* (pp. 290-300). New York: Basic Books.

Cumins, J. (1982). Test achievement in bilingual students. *Focus*, pp. 1-7.

del Valle, P., McEachern, A., & Sabina, M. (1999). Using drawings and writings in a group counseling experience with Cuban rafter children, "Los Balseritos". *Guidance and Counseling, 14*, 20-28.

Esquivel, G. B., & Keitel, M. A. (1990). Counseling immigrant children in the schools. *Elementary School Guidance and Counseling, 24*, 213-221.

Eth, S., & Pynoos, R. (1985). Children traumatized by witnessing acts of personal violence. In S. Eth & R. Pynoos (Eds.), *Post-traumatic stress disorder in children* (pp. 19-43). Washington, DC: American Psychiatric Press.

Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.

Figley, C. R. (1995). Compassion fatigue toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-28). Lutherville, MD: Sidran Press.

Figueroa, R. A., Sandoval, J., & Merino, B. (1984). School psychology with limited-English proficient (LEP) children: New competencies. *Journal of School Psychology, 22*, 121-143.

Gardner, R. A. (1993). *Story-telling in psychotherapy with children*. Northvale: Jason Aronson, Inc.

Gil, A. G., & Vega, W. A. (1996). Two different worlds: Acculturation stress and adaptation among Cuban and Nicaraguan families. *Journal of Social and Personal Relationships, 13*, 435-456.

Gonslaves, G. (1992). Psychological stages of the refugee process: A model for therapeutic interventions. *Professional Psychology: Research and Practice, 23*, 382-389.

Guarnaccia, P. J. (1997). Social stress and psychological distress among Latinos in the United States. In I. Al-Issa & M. Tousignant (Eds.), *Ethnicity, immigration, and psychopathology* (pp. 71-94). New York: Plenum Press.

Guarnaccia, P. J., & Lopez, S. (1998). The mental health and adjustment of immigrant and refugee children. *Child and Adolescent Psychiatric Clinics of North America, 7*, 537-553.

Hovey, J. D., & King, C. A. (1996). Acculturative stress, depression, and suicidal ideation among immigrant and second-generation Latino adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 1183-1192.

Howard, M., & Hodes, M. (2000). Psychopathology, adversity, and service utilization of young refugees. *Journal of American Academy of Child & Adolescent Psychiatry, 39*, 368-377.

Hubbard, J., Realmuto, G. M., Northwood, A. K., & Masten, A. S. (1995). Comorbidity of psychiatric diagnosis with post-traumatic stress disorder in survivors of childhood trauma. *Journal of American Academy of Child & Adolescent Psychiatry, 34*, 1167-1173.

Hulewat, P. (1996). Resettlement and a cultural and psychological crisis. *Social Work, 2*, 129-135.

Huyuck, E., & Fields, R. (1981) Impact of resettlement on refugee children. *International Migration Review, 15*, 246-254.

Kellogg, A., & Volker, C. A. (1993). Family art therapy with political refugees. In D. Linesch (Ed.), *Art therapy with families in crisis* (pp. 128-152). New York: Brunner/Mazel.

Kunz, E. (1972). The refugee in flight: Kinetic models and forms of displacement. *International Migration Review, 7*, 125-149.

Looney, J. G. (1979). Consulting to children in crisis. *Child Psychiatric and Human Development, 10*, 5-14.

McKelvey, R. S., & Webb, T. A. (1996). A comparative study of Vietnamese-Amerasians, their non-Amerasian siblings, and unrelated, like-aged Vietnamese immigrants. *American Journal of Psychiatry, 153*, 561-563.

Nickerson, E. T. (1983). Art as a play therapeutic medium. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 234-258). New York: Brunner/Mazel.

Orton, G. L. (1996). *Strategies for counseling with children and their parents*. Pacific Grove, CA: Brooks/Cole Publishing Company.

O'Shea, B., Hodes, M., Down, G., & Bramley, J. (2000). A school-based mental health service for refugee children. *Clinical Child Psychology and Psychiatry, 5*, 189-201.

Pennebaker, J. W. (1993). Putting stress into words: Health, linguistics, and therapy. *Behavior Research and Therapy, 31*, 539-548.

Rousseau, C., Drapeau, A., & Corin, E. (1996). Risk and protective factors in Central American and southeast Asian refugee children. *Journal of Refugee Studies, 11*, 20-37.

Sack, W. H. (1998). Multiple forms of stress in refugee and immigrant children. *Child and Adolescent Psychiatric Clinics of North America, 7*, 153-167.

Sax, G. (1997). *Principles of educational and psychological measurement and evaluation*. Belmont, CA: Wadsworth Publishing Company.

Sluzki, C. E. (1979). Migration and family conflict. *Family Process, 18*, 379-390.

Strier, D. R. (1996). Coping strategies of immigrant patients: Directions for family therapy. *Family Process, 35*, 363-376.

Stronach-Bruschel, B. (1990). Trauma, children and art. *The American Journal of Art Therapy, 29*, 48-52.

Taft, R. (1979). A comparative study of the initial adjustment of immigrant school children in Australia. *International Migration Review, 13*, 71-80.

Terr, L. C. (1990). *Too scared to cry: Psychic trauma in childhood.* New York: Harper & Row.

Thomas, C. L., & Rudolph, L. (1996). *Counseling children.* Pacific Grove, CA: Brooks/Cole Publishing Company.

United Nations High Commissioner for Refugees. (1996). *UNHCR at a Glance.* Geneva: United Nations High Commissioner for Refugees.

Webb, N. (1991). *Play therapy with children in crisis.* New York: Guilford Press.

Weine, S., Becker, D., McGlashan, T., Vojroda, D., Hartman, S., & Robbins, J. (1995). Adolescent survivors of "ethnic cleansing": Observations of the first year in America. *Journal of American Academy of Child & Adolescent Psychiatry, 34*, 1153-1159.

Williams, C. L., & Berry, J. W. (1991). Primary prevention of acculturative stress among refugees and applications of psychological theory and practice. *American Journal of Psychology, 46*, 632-641.

Zwingmann, C. A. (1973). Nostalgic behavior. In C. A. Zwingmann & M. Pfister-Ammende (Eds.), *Up-rooting and after* (pp. 142-151). New York: Springer-Verlag.

Section

5

Tertiary Prevention: Long-Term Treatment of Traumatized Individuals

It is essential that we consider the long-term impact of a crisis on children and youth and provide appropriate support and assistance during the following months and years. The chapters in this section address many of these long-term considerations. The first chapter in this section emphasizes important information regarding diagnosing child and adolescent posttraumatic stress disorder (Chapter 30 by Philip Saigh and Anastasia Yasik). The next chapter highlights the use of cognitive-behavioral treatment of posttraumatic stress disorder in children and adolescents (Chapter 31 by Philip Saigh).

It is estimated that, by high school, as many as 90% of youth experience the death of a close or special person. Thus, the chapter addressing how children grieve (Chapter 32 by Alan Wolfelt) is particularly relevant. It will help educators work with children following a loss.

This section on tertiary prevention concludes with a comprehensive review of innovative treatment methods for childhood trauma (Chapter 33 by Kathleen Nader). This chapter includes an extensive reference listing that may be of particular interest to many readers.

As indicated in the introduction to this book, the immediate response (i.e., crisis intervention) is insufficient when addressing the needs of individuals with significant psychological injury (e.g., posttraumatic stress disorder). Although intensive treatment may not fall within the educational mandates of schools, this work is necessary in facilitating healthy adaptation and adjustment. Consequently, it is necessary that schools assist traumatized youths to get the professional mental health help they need to function as effective students.

30

危機

Diagnosing Child-Adolescent Posttraumatic Stress Disorder

Philip A. Saigh, Ph.D.
City University of New York

Anastasia E. Yasik, Ph.D.
Pace University

This chapter focuses on the diagnostic assessment of traumatized youths. It is specifically intended to describe clinical procedures that may be used to generate clinical diagnoses as based on the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV; American Psychiatric Association (APA), 1994] criteria for posttraumatic stress disorder (PTSD).[1] In identifying PTSD in youths, a multisource, multimethod assessment paradigm (March, 1999; Saigh, 1992b) is advocated. The description multisource denotes that several sources of information (i.e., parent, child, medical personnel) should be used. The descriptor multimethod denotes that several assessment procedures (i.e., clinical interviews, structured interviews) should be used to formulate diagnoses. We recommend that the child-adolescent PTSD assessment process should involve a team approach because the formulation of categorical diagnoses may be affected by examinee variance (e.g., an examinee may withhold and/or acknowledge different symptoms when questioned by different examiners). The use of several examiners is particularly useful when assessing children under age six or youths with IQs of 79 or less. A team approach is also useful in dealing with threshold cases (i.e., examinees whose symptom presentation is very close to the DSM standard for meeting or not meeting diagnostic criteria). In these instances, the use of multiple interviewers may facilitate the acquisition of more comprehensive symptom profiles.

Interviews

Interviews have traditionally been used to establish inferences in clinical settings. In effect, an interview "involves a series of interactions, frequently in question and answer format, that are used in formulating inferences" (Saigh, 1992a, p. 142). Operationally, interviews generally follow a structured or unstructured format. The former involves a standardized process wherein examiners present questions according to a specified protocol. The latter entails nonstandardized questions or probes that are indicative of the examiner's personal knowledge and ongoing clinical observations. Although unstructured interviews may yield a wealth of information, they are susceptible to information variance [i.e., differences in the quantity and quality of information that is obtained from the same examinee by different examiners (Saigh, 1992a; Spitzer, Endicott, & Robins, 1978)]. Edelbrock and Costello (1990) caution that the use of unstructured interviews with parents and children "is a universal, and arguably an indispensable, component of clinical assessment of children and youth. Yet, it is one of the least trustworthy assessment procedures, subject to broad variations in content, style, detail, and coverage" (p. 308). Edelbrock and Costello further caution that "interviewers differ in *what they ask* and *how they ask it*. They undoubtedly influence responses directly through the choice of a particular line and style of questioning and indirectly through their verbal and nonverbal reactions" (p. 308). These authors suggest that assessment can be made more reliable by structuring the interview process. Structuring involves limiting the question and answer interactions between the interviewer and the examinee. According to Edelbrock and Costello, "this is accomplished by *defining* the phenomena to be assessed, *limiting* the order and wording of questions, and *standardizing* how responses are rated, recorded, combined, and interpreted" (p. 308). Whereas standardized interviews appreciably augment reliability, the exclusive use of this assessment modality may preclude the use of clinically valuable questions (Saigh, 1992a). In view of this, the position advocated herein is to formulate diagnoses on the basis of structured and unstructured interview data.

Unstructured Clinical Interviews

While the epidemiological literature clearly indicates that exposure to traumatic events was insufficient to induce PTSD in the majority of cases, it may also be said that a host of stressors (e.g., physical or sexual assault, accidents, disasters, and severe illness) was capable of inducing the disorder among a subset of youths (Saigh, Yasik, Sack, & Koplewicz, 1999). Given the apparent risk for PTSD following traumatic experiences and the advantages that are associated with establishing diagnoses, it is of the utmost importance to determine if traumatized youths have PTSD. In so doing, it is recommended that mental health examiners interview caregivers and affected youths.

Caregiver Clinical Interviews

Before meeting a traumatized youth, professional examiners should review available hospital, school, or agency records that pertain to the case. Examiners should also meet and interview the parents or guardians of the affected youth. At these meetings, the examiner should determine exactly what happened to the child, when the incident occurred, and how the child has functioned since he or she was traumatized. If the child was injured and is receiving medical services, information involving the nature of the injury, prognosis, and treatment should be obtained. Likewise, information involving premorbid medical or psychiatric conditions should be obtained.

It is strongly recommended that examiners interview the primary caregiver(s) in order to establish if the youth meets DSM-IV (1994) criteria for PTSD. Although there are no clearcut rules on how to conduct a clinical interview, examiners should systematically inquire if the child does or does not evidence the symptoms that comprise the DSM-IV PTSD classification. As the diagnosis of PTSD rests in part on the presence of functional impairment, examiners should determine if a youth's conduct at home, school, or the community has been adversely influenced. In effect, examiners should determine if the child has been avoiding social interactions or fighting at home or at school since the incident. As youths with PTSD may evidence significantly subaverage academic achievement (Saigh, Mroueh, & Bremner, 1997), examiners also should determine if school performance has deteriorated since the incident. A school report card may provide a graphic example of functional impairment over time. Likewise, standardized academic achievement test scores may also serve to reflect potential premorbid and postmorbid variations in achievement.

Child-Adolescent Clinical Interviews

Whenever possible, examiners should be introduced to the traumatized youth by his or her primary caregiver(s). It is advised that the child's caregivers be absent when the interview takes place because affected youths may be reluctant to describe their experiences and feelings in the presence of their caregivers. As validity of the child interview depends in part on the youth's ability to understand what is being asked, a reliable and valid individually administered index of cognitive ability such as the WISC-III should be administered before assessing for PTSD whenever cognitive ability is in doubt. Our clinical research with traumatized children at Bellevue Hospital (Saigh, Yasik, Sack, & Koplewicz, 1999; Saigh et al., 2000; Yasik et al., 2001) has consistently demonstrated that youths with intelligence scores in the deficient and borderline range find it difficult to understand the questions that are needed to formulate a PTSD diagnosis. We have also repeatedly noted that such youths provide inconsistent answers. As such, examiners may wish to forgo direct assessment in these cases and rely on caregiver interviews and anecdotal information to formulate differential diagnoses.

It is highly recommended that examiners establish rapport with the youth before interviewing for PTSD. While there is little empirical information to support the efficacy of different rapport-building techniques, Morrison (1995) intuitively argues that, "If you appear relaxed, interested, and sympathetic, your patient is more likely to feel safe and comfortable" (p. 24). He also cautions against frowning, grimacing, or showing other signs of disapproval. In addition, the judicious use of "smiles and nods, when appropriate to the content of the discussion, will make it clear that you are attentive and sympathetic" (p. 24).

Almost invariably, children and adolescents are hesitant to discuss traumatic experiences because these discussions may induce a great deal of situational distress (Saigh, 1992a). Although this sort of distress may not be avoided, it may help to remind examinees that information involving his or her traumatic experience and current feelings are needed to determine if a problem exists and will improve treatment considerations.

After establishing rapport, the examiner should inquire if the youth has had a very frightening experience. At this stage of the interview, we recommend that the child be allowed to tell his or her story. If the examiner was advised by a referent or an objective source of information that the examinee was exposed to an extreme form of stress and the examinee fails to acknowledge this, the examiner should say: "*Mr./ Ms./ Dr./ Your records* (name the referent, informant, or specific agency record) *told me/ indicated* … (briefly describe the event). *Can you tell me about this?*" If the examinee does so, examiners should record the actual statement. If the examinee continues to deny exposure to a reported event, the interview should be temporarily discontinued and the examiner should attempt to engage the examinee in a nonthreatening conversation or activity that is intended to put the youth at ease. Following this, the examiner should attempt to discuss the reported incident with the examinee. If these efforts are successful, the child should be asked to describe the incident and the examiner should record the statement verbatim. If the examinee refuses to acknowledge the incident, the interview should be terminated. In these relatively infrequent situations, examiners must rely on feedback from the child's caregivers and available records to formulate clinical diagnoses.

After inquiring about the youth's exposure to extreme stress, the examiner should systematically ask if the youth is experiencing the symptoms that are indicative of the PTSD classification. Efforts should be made to solicit answers that go beyond "Yes" or "No" by asking the child to provide examples or tell in his or her own words how symptoms are experienced. As noted under the recommendations for the caregiver interviews, examiners should also determine if functional impairments are apparent. In so doing, examiners need to ask if the youth's conduct at home, school, or in the community has been adversely influenced. Likewise, examiners should ask if an examinee's ability to concentrate has been affected or if school grades deteriorated following the incident. Given that youths with PTSD may also have comorbid disorders [e.g., attention-deficit/hyperactivity disorder (ADHD), affective disorders, and or substance-related disorders; Saigh, Yasik, Sack, & Koplewicz, 1999], examiners should systematically interview traumatized youths to determine if additional diagnoses are warranted.

Structured Interviews

Structured Interviews for Children and Adolescents

To date, a number of DSM-IV (1994) based child-adolescent PTSD structured interviews have been constructed. Pynoos, Rodriguez, Sternberg, Stauber, and Frederick (1998) developed the UCLA PTSD Index for DSM-IV Child Version. In a similar vein, Amaya-Jackson, McCarthy, Cherney, and Newman (1995) developed the Child PTSD Checklist. Albano and Silverman's (1996) Anxiety Disorders Interview Schedule for DSM-IV: Child Version includes a PTSD module. Likewise, Shaffer, Fisher, Lucas, Dulcan, and Schwab-Stone's (2000) NIMH Diagnostic Interview Schedule for Children, Version IV includes a PTSD module. Whereas these measures were developed to diagnose child-adolescent PTSD, information about their psychometric properties has not been reported in the literature.

The Schedule for Affective Disorders and Schizophrenia for School Age Children (K-SADS), which is available in several different versions (e.g., Epidemiologic version, Present/Lifetime version, Present State-IV-Revised; Ambrosini, 2000), contains a PTSD module that reflects the DSM-III-R (1987) and DSM-IV (1994) diagnostic criteria. Instructions indicate that the parent and child should be independently interviewed and diagnoses formulated on the basis of the combined input. Within the context of a pilot study for the K-SADS-PL, Kaufman et al. (1997) determined the reliability of the PTSD module. The *kappas*[2] based on administrations to 20 youths and their parents were 0.67 for a present diagnosis and 0.60 for a lifetime diagnosis.

In addition, within the context of DSM-IV (1994) child-adolescent diagnostic interviews, Reich, Leacock, and Shanfeld (1994) developed the Diagnostic Interview for Children and Adolescents-Revised (DICA-R). This broad-based interview includes a PTSD module that may be used to formulate diagnoses based on the DSM-III-R (1987) or DSM-IV criteria. Reich (personal communication, August 8, 1998) administered the instrument to 50 clinically referred youths with a mean age of 11 years and observed an internal consistency *alpha*[3] of 0.79 at the diagnostic level. Reich also compared clinically derived diagnoses with DICA-R PTSD module generated diagnoses, and 100% agreement was observed yielding a sensitivity[4] of 1.00 and a specificity[5] of 0.86.

In a related study, Yasik et al. (1998) administered the DICA-R PTSD module to 37 stress-exposed inner-city youths. The authors reported internal consistency *alpha* coefficients of 0.44, 0.87, 0.83, and 0.87 for the reactivity, reexperiencing, avoidance and numbing, and increased arousal subtests, respectively. An *alpha* coefficient of 0.94 was reported for the omnibus item pool. Employing clinically derived expert ratings, Yasik et al. determined that the DICA-R correctly identified 9 of 15 cases (sensitivity = 0.60) that had been clinically diagnosed as PTSD positives and 33 of 34 cases that were diagnosed as PTSD negatives (specificity = 0.97). Overall, the DICA-R PTSD module correctly identified the diagnostic status of 85.7% of the cases. Based on comparisons of clinician derived diagnoses and those obtained by the DICA-R PTSD module, a *kappa* of 0.94 was reported.

Nader et al. (1996) developed the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA). Newman et al. (1998) subsequently administered the instrument to 50 incarcerated male adolescents and observed internal consistency *alpha* coefficients of 0.81, 0.75, and 0.79 for the reexperiencing, numbing and avoidance, and increased arousal symptom clusters, respectively. Newman et al.'s unpublished research also yielded a Pearson product-moment coefficient of 0.64 when the CAPS-CA was correlated with the Amaya-Jackson et al. (1995) Child PTSD Checklist.

Costello, Angold, March, and Fairbank (1998) administered the Child and Adolescent Psychiatric Assessment (CAPA; Angold et al., 1995) PTSD module to 58 youths at a child guidance clinic. The module was also administered to a child-adolescent community sample (n = 1,015). A *kappa* coefficient was computed based on nine subjects endorsing the three screening symptoms (not symptom clusters). At the overall PTSD diagnostic level, a *kappa* of 0.64 was reported. The overall intraclass correlation coefficient (ICC)[6] for the CAPA was 0.94. The rates of reported traumatic events and symptoms endorsed by the clinical and community samples were also compared. Data analysis revealed that approximately twice as many clinical participants reported traumatic incidents as compared to community participants. Data analysis also determined that 8.6% of the clinical sample met criteria for PTSD as compared to 0.5% of the community sample. The authors reported that the variance in PTSD prevalence was supportive of the differential validity of the instrument.

Fletcher (1996) developed the Childhood PTSD Interview and administered the instrument to 10 participants from a clinical sample with a history of stress-exposure and 20 youths from a community setting without a history of significant-stress exposure. On the basis of these administrations, he reported Kuder-Richardson formula 20 (KR-20)[7] coefficients of 0.52, 0.80, 0.76, and 0.78 for the PTSD stress-exposure, reexperiencing, numbing and avoidance, and increased arousal symptom clusters, respectively. A coefficient of 0.91 was reported for the overall scale. The Childhood PTSD Interview was moderately correlated ($r = 0.60$) with Fletcher's Childhood PTSD Interview - Parent Form. In addition, the Childhood PTSD Interview was also correlated ($r = 0.87$) with a paper and pencil self-report index of PTSD that the author developed (i.e., the When Bad Things Happen Scale). The Childhood PTSD Interview was also moderately correlated ($r = 0.52$) with a suggested PTSD subscale (Wolfe, Gentile, & Wolfe, 1989) of the Child Behavior Checklist (CBCL; Achenbach, 1991).

Given the apparent paucity of diagnostic instruments with adequate psychometric properties, Saigh (1998a, 1998b) developed a DSM-IV (1994) version of the Children's PTSD Inventory. The instrument was initially field tested with a sample of 50 South African female adolescent rape victims (Heitz & Saigh, 1994). As based on preliminary data analysis and clinical feedback from the test administrators at a number of additional sites, a number of items were added, deleted, or modified. Three psychologists who served on the DSM-IV PTSD work group subsequently reviewed the revision. A minority school psychologist, two board-certified child psychiatrists, a school psychologist, two elementary school teachers, and a minority social worker also reviewed the instrument. Given their informed feedback, a number of items were added, modified, or deleted.

These efforts led to the development of an instrument that consists of five subtests. Instructions regarding test administration and scoring are directly presented within the instrument. After each subtest, specific instructions are provided for scoring. Following a preface that provides examples of traumatic incidents, the first subtest lists four questions involving potential exposure to traumatic incidents as well as four questions denot-

Table 1

Examples of Exposure and Situational Reactivity Items From the Children's PTSD Inventory

---

A 1. EXPOSURE

SAY: *"Sometimes very scary things can happen to young people. Some of them have been badly beaten or taken away from their parents. Others have been hurt in accidents or fires. Sometimes people have done bad things to the private parts of young people. Children and teenagers have also been hurt in wars. Others have seen people who were badly injured or killed in their homes or neighborhoods."*

1a. **SAY:** *"Has a very scary thing happened to you?"*

CHECK: Yes: _____ No: _____

If "Yes" was indicated, **SAY:** *"Tell me about it."*

RECORD the Examinee's actual statement. _____________________

A 2. SITUATIONAL REACTIVITY

1. **SAY:** *"Were you very scared when this happened?"*

CHECK: Yes: _____ No: _____

2. **SAY:** *"Did you feel very upset when this happened?"*

CHECK: Yes: _____ No: _____

3. **SAY:** *"Did you feel that you could not do anything to stop this from happening?"*

CHECK: Yes: _____ No: _____

Note
From Saigh, P. A. (1998a). *Children's PTSD Inventory (DSM-IV Version).* Privately printed. New York, New York. Copyright Philip A. Saigh, Ph.D. Reprinted with permission. All rights reserved. Information pertaining to the instrument should be addressed to Philip A. Saigh, Ph.D., Doctoral Program in Educational Psychology, Graduate School and University Center, City University of New York, 365 Fifth Avenue, New York, NY 10016. Electronic mail may be sent to *PASaigh@aol.com*

Table 2

Examples of Items on the Children's PTSD Inventory

Reexperiencing Symptoms

"Are you having a lot of upsetting thoughts about what happened?"
"Do pictures about what happened keep popping into your head?"
"Are you having a lot of bad dreams about what happened?"

Avoidance and Numbing Symptoms

"Are you trying not to think about what happened?"
"Have you been trying not to have feelings about what happened?"
"Have you been trying to stay away from places that remind you about what happened?"

Increased Arousal

"Since this happened, has it been difficult to go to sleep or stay asleep at night?"
"Since this happened have you been getting very angry?"
"Since this happened, have you become very careful or watchful?"

Significant Distress

"Have you been having more problems with your teachers since this happened?"
"Have your grades in school gotten worse since this happened?"

Note
From Saigh, P. A. (1998a). *Children's PTSD Inventory (DSM-IV Version)*. Privately printed. New York, New York. Copyright Philip A. Saigh, Ph.D. Reprinted with permission. All rights reserved.

ing reactivity during stress exposure. Table 1, on page 625, presents the preface and some of the questions that were designed to denote reactivity upon stress-exposure.

Table 2 presents sample items from the different symptom clusters and significant impairment sections of the Children's PTSD Inventory (Saigh, 1998a, 1998b). The second subtest consists of 11 questions that denote the presence or absence of reexperiencing symptoms. Avoidance and numbing are assessed with 16 items included in the third subtest. The fourth subtest presents seven questions denoting increased arousal, and the fifth subtest lists five questions involving significant impairment. The instrument yields the following diagnoses: PTSD Negative, Acute PTSD, Chronic PTSD, Delayed Onset PTSD, and No Diagnosis. The latter category is reserved for situations wherein the examiner has been advised by a referent or an objective source of information that an examinee was exposed to an extreme form of stress and the examinee fails to acknowledge stress exposure.

To establish the content validity of the instrument (Saigh et al., 2000), one of the co-chairs and two members of the DSM-IV PTSD Work Group independently rated the Children's PTSD Inventory items for correspondence with the current diagnostic criteria according to a 0 - 100 point Likert-type scale (e.g., 0 = lowest correspondence, 50 = average correspondence, and 100 = highest correspondence) with 10-unit intervals. The expert judges had never seen or been consulted about the instrument prior to independently rating the measure. The Situational Reactivity subtest had a mean rating of 86.67 with a standard deviation of 5.77. The Reexperiencing subtest had a mean of 90 with a standard deviation of 10. The Exposure, Avoidance and Numbing, Increased Arousal, and Significant Impairment subtests each received a mean rating of 90.00 with a standard deviation of 0.00. These ratings consistently indicated high levels of perceived correspondence between the Children's PTSD Inventory and the DSM-IV PTSD diagnostic criteria.

The instrument was subsequently administered to 67 stress-exposed and 16 nontraumatized youths at Bellevue Hospital (Saigh et al., 2000). Moderate to high Cronbach *alphas* (0.53 - 0.89) were evident at the subtest level. An *alpha* of 0.95 was evident at the diagnostic level. In terms of inter-rater reliability, 97.6% agreement and 2.4% disagreement was evident at the diagnostic level. Inter-rater ICCs ranged from 0.88 to 0.96 at the subtest level and 0.98 for the diagnostic level. Moderate to high *kappas* (0.65 - 1.00) were reported for inter-rater reliability at the subtest level. An inter-rater reliability *kappa* of 0.98 was evident at the diagnostic level. In terms of reliability, 96.5% agreement was evident at the diagnostic level. Moderate to high *kappas* (0.67 - 1.00) and ICCs (0.66 - 0.93) were observed. A *kappa* of 0.87 and an ICC of 0.88 was observed at the diagnostic level.

The criterion and construct validity of the Children's PTSD Inventory was addressed by administering the measure to 73 traumatized and 22 nontraumatized youths at Bellevue Hospital (Yasik et al., 2001). Responses to the Children's PTSD Inventory items were compared with responses derived through clinical interviews as well as the DICA-R and Structured Clinical Interview for DSM-IV (SCID; First, Gibbon, Williams, & Spitzer, 1996) PTSD module administrations. Moderate to high levels of sensitivity (0.91 - 1.00), specificity (0.90 - 0.97), positive (0.68 - 0.94) and negative (0.95 - 1.00) predictive power,[8] and diagnostic efficiency[9] (0.92 - 0.95) were evidenced across the three criterion measures. Significant correlations with the Revised Children's Manifest Anxiety Scale ($r = 0.74$) (RCMAS; Reynolds & Richmond, 1985), Children's Depression Inventory ($r = 0.65$) (CDI; Kovacs, 1992), and the Junior Eysenck Personality Inventory (JEPI; Eysenck, 1963) Neuroticism scale ($r = 0.59$) provided evidence for the construct validity of the instrument. Convergent and discriminant validity[10] were evident through a significant correlation with the CBCL Internalizing scale ($r = 0.52$) along with a nonsignificant association with the JEPI Extraversion scale ($r = -0.08$) and CBCL Externalizing scale ($r = 0.19$).

While it is apparent that a number of DSM-IV (1994) based child-adolescent PTSD structured interviews have been developed, the psychometric properties of the majority of the child-adolescent PTSD interviews have not been extensively researched. Only five studies reported information on internal consistency (Fletcher, 1996; Newman et al., 1998; Reich, personal communication, August 8, 1998; Saigh et al., 2000; Yasik et al., 1998), only two studies reported information on stability over time (Costello et al., 1998; Saigh et al., 2000), and only one study reported information on inter-rater reliability (Saigh et al., 2000). Moreover, only one study (Saigh et al., 2000) offered empirical evidence to support content validity relative to the universe of definition that is being measured (i.e., the DSM-IV PTSD criteria). The paucity of research involving content validity presents a serious challenge to the classification process as a number of the earlier DSM-III (1980) and DSM-III-R (1987) child-adolescent PTSD measures had item pools that were incongruent with the psychiatric nomenclature (c.f., Husain et al., 1998; Lonigan, Shannon, Finch, Daughtery, & Taylor, 1991; Saigh, Yasik, Sack, & Koplewicz, 1999; Vogel & Vernberg, 1993). Certainly, researchers and clinicians should not assume that an instrument is indicative of the current diagnostic nomenclature without empirical justification (Kamphaus & Frick, 1996). Thus far, only five test developers reported information regarding criterion-related validity (Fletcher, 1996; Newman et al., 1998; Reich, personal communication, August 8, 1998; Yasik et al., 1998; Yasik et al., 2001), and only three investigations report information involving construct validity (Costello et al., 1998; Fletcher, 1996; Yasik et al., 2001). It is also of some concern to observe that the psychometric properties of the majority of child-adolescent PTSD structured interviews have not been published in peer-reviewed journals with two exceptions. At this time, information involving the psychometric properties of the CAPA and the Children's PTSD Inventory has been reported in refereed journals (Costello et al., 1998; Saigh et al., 2000; Yasik et al., 2001), and information pertaining to reliability and validity of the remaining child-adolescent PTSD interviews is limited to personal communications or material reported at conferences.

Structured Interviews for Parents

As in the case of child-adolescent structured interviews, a number of DSM-IV (1994) based parental interviews have been developed. In contrast to the CAPA, DISC-IV, and DICA-R, the K-SADS determines diagnostic status on the basis of combined child and parent report (Ambrosini, 2000). As such, the K-SADS psychometric properties that were reported in the previous section apply to both child and parent informants. Whereas the DISC-P (Shaffer, Lucas, & Richters, 1999) and DICA-R-P (Reich, 2000) are appropriate for parents of children and adolescents, information regarding the basic psychometric properties of the DSM-IV PTSD modules that are contained in these instruments has not been published to date.

The parent version of the CAPA was administered to the parents of nine youths who responded positively to screening items thought to be associated with PTSD

(Costello et al., 1998). A *kappa* coefficient of 0.54 and an ICC of 0.99 were reported for the overall diagnostic module. Evidence for the discriminant validity of the CAPA parent interview was presented by Costello et al. (1998) in terms of the differential rates of PTSD in clinic and community samples. Whereas 5.3% of clinic participants were diagnosed with PTSD based on parent informants, only 0.4% of community participants were diagnosed with PTSD.

An instrument developed solely for the purpose of assessing PTSD in youths on the basis of parent report is the Childhood PTSD Interview - Parent Form (Fletcher, 1996). This interview was administered to the parents of 30 children (10 traumatized clinic youths, 20 community youths). KR-20 internal consistency estimates for the stress-exposure, reexperiencing, avoidance and numbing, and increased arousal symptom clusters were 0.60, 0.86, 0.86, and 0.83, respectively. The internal consistency for the overall scale was 0.94. Evidence for the validity of the Parent Form was provided in the form of moderate correlations with child responses on the Childhood PTSD Interview ($r = 0.69$) and scores on Wolfe et al.'s (1989) proposed CBCL PTSD subscale ($r = 0.78$). In addition, Fletcher notes a significant difference in Parent Form scores between traumatized clinic youths and the community samples.

Structured Clinical Interviews for Assessing Comorbid Psychiatric Conditions

Given that children and adolescents with PTSD frequently present with comorbid disorders such as ADHD, conduct disorder (CD), major depression (MD), oppositional defiant disorder (ODD), and substance-related disorders (Saigh, Yasik, Sack, & Koplewicz, 1999), the assessment of comorbid disorders is an essential element of the psychodiagnostic process. Currently, there are several well-established child-adolescent structured clinical interviews that may be used to formulate DSM-IV (1994) diagnoses. The CAPA, DISC-IV, DICA-R, and K-SADS have been widely used for clinical and epidemiological purposes. Although these interviews differ in format, they contain major diagnostic modules of relevance for assessing comorbidity that may be associated with PTSD (Shaffer et al., 1999). For instance, all four interviews contain modules for DSM-III-R (1987) and DSM-IV behavior disorders (e.g., ADHD, CD, or ODD), anxiety disorders (e.g., simple phobia, social phobia), depressive disorders (e.g., major depression, dysthymia), substance use/abuse (e.g., tobacco, alcohol, cannabis, cocaine/crack), and psychotic symptoms or disorders.

Angold et al. (1995) developed the CAPA interview with a separate parent version appropriate for the parents of children from 3- to 17-years-old. The ADHD module is the only module administered exclusively to parents. Due to a concern regarding the reliability of child symptom reports beyond a three-month time period, the CAPA focuses on symptom presentation within the three months preceding the interview (Angold & Costello, 2000) and as such is the only one of these instruments that does not provide lifetime diagnoses.

The DICA-R is available in child (DICA-C-R; age range 6 to 12), adolescent (DICA-A-R; age range 13 to 17), and parent versions (DICA-P-R) that differ only slightly in the wording of questions (Reich, 2000). Reich administered the DICA-C-R to 30 outpatients and 10 community youths (25 girls, 15 boys) over a one-week time period. The *kappa* coefficients were 0.32 for ADHD, 0.46 for ODD, 0.55 for MD, 0.55 for overanxious disorder, 0.60 for separation anxiety, and 0.65 for simple phobia. Based on the administration of the DICA-A-R to 35 adolescents, the *kappas* were 0.59 for ADHD, 0.60 for ODD, 0.92 for CD, 0.80 for MD, 0.72 for overanxious disorder, and 0.75 for separation anxiety. The *kappas* for the substance dependence modules ranged from 0.66 for hallucinogen dependence to 1.00 for speed dependence (Reich, personal communication, April 6, 2000). Based on a sample of 60 child-adolescent psychiatric inpatients, the *kappa* for the psychotic symptoms module was reported to be 0.76 (Reich, personal communication, April 6, 2000). Validity of the instrument was supported in a clinical study, which demonstrated that children of parents with a diagnosis of bipolar disorder exhibited more psychopathology than children of parents without a DSM diagnosis (Reich, 2000). Reich (personal communication, February 5, 2001) also reported sensitivity coefficients of 0.85, 0.92, 0.82, 1.00, and 1.00 for the ADHD, CD, MDD, substance dependence, and psychotic symptom modules. Specificity coefficients of 0.73, 0.71, 0.72, 0.80, and 0.72 were reported for the respective modules.

Analogously, a number of versions of the DISC-IV are available for youths (DISC-Y; 9 to 17 years) and parents (DISC-P). Fisher et al. (1997; cited by Shaffer et al., 2000) administered the DISC-IV to 82 children (age range 9 to 17) and 84 parents in an outpatient setting. Based on child report, the *kappas* were 0.42 for ADHD, 0.51 for ODD, 0.65 for CD, 0.92 for MD, 0.68 for specific phobia, 0.25 for social phobia, and 0.46 for separation anxiety. Coefficient *kappas* based on administration of the DISC-P were 0.79 for ADHD, 0.54 for ODD, 0.43 for CD, 0.66 for MD, 0.96 for specific phobia, 0.54 for social phobia, 0.58 for separation anxiety, and 0.65 for generalized anxiety disorder. Information regarding the validity of the DSM-IV (1994) versions of the DISC-Y and DISC-P has not been published.

As noted previously, diagnoses derived from the K-SADS reflect information obtained from both parent and child. In their pilot study of the instrument, Kaufman et al. (1997) administered the K-SADS-PL to 55 psychiatric outpatients and 11 nonclinical controls. Information regarding reliability was limited to diagnoses for which sufficient numbers (n = 20) were available to calculate *kappa*. As such, *kappas* were available for five diagnostic areas, including PTSD (*kappa* reported earlier). The other four diagnostic modules assessed and their respective *kappas* for a present diagnosis were: ADHD (0.63), ODD (0.74), MD (0.90), and GAD (0.78). The *kappa* for CD was 0.83 based only on lifetime diagnoses. In terms of concurrent validity, diagnoses obtained with the K-SADS-PL were compared on the CBCL. Youths diagnosed with a depressive disorder scored significantly higher on the CBCL Internalizing scale than did the other youths. Analogously, youths diagnosed with a behavior disorder (i.e., ADHD, CD, or ODD) scored significantly higher on the CBCL Externalizing scale than youths without such diagnoses (Kaufman et al., 1997).

6-6

Nondiagnostic Self-Report Inventories and Rating Scales

To date, a number of studies have examined the differential validity of the PTSD classification with children and adolescents. These studies were primarily carried out in order to test the validity of the PTSD classification. In so doing, nondiagnostic estimates of psychopathology have been administered to youths with PTSD as well as youths with a related anxiety disorder, traumatized youths without PTSD, and nonclinical controls. In all of these studies, diagnostic status was established through administrations of structured and/or clinical interviews (i.e., the "gold standards" for diagnosing PTSD). For example, Saigh (1989b) administered the RCMAS, CDI, Test Anxiety Inventory (TAI; Spielberger, 1980), and the Conners Teacher Rating Scale (CTRS; Conners, 1969) to three groups of adolescents. The first group met criteria for PTSD as diagnosed by the DSM-III (1980) version of the Children's PTSD Inventory (Saigh, 1989a). The second group presented with test phobia, and the third group consisted of nonclinical controls. Saigh reported that the PTSD group evidenced significantly higher levels of morbidity on the RCMAS, CDI, and CTRS than did the phobic and nonclinical controls. It was also apparent that test phobic youths had significantly higher TAI scores than their counterparts. Moreover, the test-phobic participants had significantly higher RCMAS and CDI scores than the nonclinical controls.

In a similar vein, Saigh, Yasik, Oberfield, et al. (1999) at Bellevue Hospital compared the CBCL ratings of youths with PTSD, traumatized youths without PTSD, and nonclinical controls [as identified by administrations of the DSM-IV (1994) version of the Children's PTSD Inventory and clinical interviews]. Data analysis indicated that youths with PTSD had significantly higher estimates of psychopathology on most of the CBCL measures relative to the ratings of traumatized youths without PTSD and the nonclinical control group. Nonsignificant differences were observed when the CBCL ratings of the traumatized PTSD negatives and controls were compared. While these studies speak well for the differential validity of the PTSD classification and may highlight pathological levels of trait anxiety, depression, and misconduct, measures like the RCMAS, CDI, and CBCL do not generate DSM-IV diagnoses. The diagnosis of PTSD and potential comorbid psychiatric disorders can only be made through clinical interviews and the administration of psychometrically sound, structured interviews that denote diagnostic criteria that is specified in the DSM-IV.

Summary and Future Directions

Given that children and adolescents are frequently exposed to serious accidents, major illnesses, natural disasters, and sexual or physical assault (Saigh, Yasik, Sack, & Koplewicz, 1999) and given that a traumatic exposure may lead to the development of PTSD (APA, 1994), school mental health professionals should be prepared to diagnose the disorder. In this chapter we recommend that a multisource, multimethod assessment paradigm be used in formulating diagnoses. Whereas unstructured clinical interviews may provide a wealth of clinical insights, these elements are less reliable than structured clinical interviews. Therefore, we recommend the use of both structured and unstructured caregiver and child-adolescent interviews.

With a few exceptions, the psychometric properties of the child-adolescent PTSD interviews have not been extensively researched. This is of significance given Anastasi and Urbina's (1998) concern that "the trait measured by a given test can be defined only through an examination of the objective sources of information and empirical operations utilized in establishing its validity" (p. 113). Consequently, we recommend that the use of child-adolescent PTSD diagnostic tools be limited to measures with well-defined and clearly documented psychometric properties that are commensurate with the standards of the AERA, APA, and NCME (1999).

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

Albano, A., & Silverman, W. (1996). *Anxiety Disorders Interview Schedule for DSM-IV: Child Version*. San Antonio, TX: Psychological Corporation.

Amaya-Jackson, L., McCarthy, G., Cherney, M. S., & Newman, E. (1995). Child PTSD Checklist. Duke University Medical Center. Unpublished manuscript.

Ambrosini, P. J. (2000). Historical development and present status of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS). *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 49-58.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. revised). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.

Anastasi, A., & Urbina, S. (1998). *Psychological testing* (7th ed.). Upper Saddle River, NJ: Prentice-Hall.

Angold, A., & Costello, E. J. (2000). The Child and Adolescent Psychiatric Assessment (CAPA). *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 39-48.

Angold, A., Prendergast, M., Cox, A., Harrington, R., Simonoff, E., & Rutter, M. (1995). The Child and Adolescent Psychiatric Assessment (CAPA). *Psychological Medicine, 25*, 739-753.

Bartko, J. J., & Carpenter, W. T. (1976). On the methods and theory of reliability. *Journal of Nervous and Mental Disease, 163*, 307-315.

Conners, C. K. (1969). A teacher rating scale for use in drug studies with children. *American Journal of Psychiatry, 126*, 884-888.

Costello, E. J., Angold, A., March, J., & Fairbank, J. (1998). Life events and post-traumatic stress: The development of a new measure for children and adolescents. *Psychological Medicine, 28*, 1275-1288.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*, 297-334.

Edelbrock, C., & Costello, A. J. (1990). Structured interviews for children and adolescents. In G. Goldstein & M. Hersen (Eds.), *Handbook of psychological assessment* (2nd ed.) (pp. 308-323). New York: Pergamon.

Eysenck, S. B. (1963). *Junior Eysenck Personality Inventory*. San Diego, CA: Educational and Industrial Testing Service and Human Services.

First, M., Gibbon, M., Williams, J. B., & Spitzer, R. L. (1996). *Structured Clinical Interview for the DSM-IV (SCID)*. (Available from Biometrics Research Department, New York State Psychiatric Institute, New York, NY 10032)

Fisher, P. W., Lucas, C., Shaffer, D., Schwab-Stone, M. M., Dulcan, M., Graae, F., Lichtman, J., Willoughby, S., & Gerarld, J. (1997, October). *Diagnostic Interview Schedule for Children Version IV (DISC-IV): Reliability in a clinical sample.* Poster presented at the 44th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Toronto, Canada.

Fletcher, K. E. (1996, November). *Measuring school-aged children's PTSD: Preliminary psychometrics of four new measures.* Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, San Francisco, CA.

Fleiss, J. L. (1981). *Statistical methods for rates and proportions* (2nd ed.). New York: Wiley.

Heitz, B., & Saigh, P. A. (1994). The psychometric properties of the Children's PTSD Inventory among a sample of South African females. [Unpublished data].

Hennekens, C. H., & Buring, J. E. (1987). *Epidemiology in medicine.* Boston: Little, Brown, and Company.

Husain, S. A., Nair, J., Holcomb, W., Reid, J. C., Vagras, V., & Nair, S. S. (1998). Stress reactions of children and adolescents in war and siege conditions. *American Journal of Psychiatry, 155,* 1718-1719.

Kamphaus, R. W., & Frick, P. J. (1996). *Clinical assessment of child and adolescent personality and behavior.* Needham Heights, MA: Allyn & Bacon.

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., Williamson, D., & Ryan, N. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry, 36,* 980-988.

Kovacs, M. (1992). *The Children's Depression Inventory.* North Tonowanda, NY: Multi-Health Systems.

Lonigan, C., Shannon, M., Finch, A., Daughtery, T., & Taylor, C. (1991). Children's reactions to a natural disaster: Symptom severity and degree of exposure. *Advances in Behavior Research and Therapy, 13,* 135-154.

March, J. (1999). Assessment of pediatric posttraumatic stress disorder. In P. A. Saigh, & J. D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive text* (pp. 199-218). Needham Heights, MA: Allyn & Bacon.

Morrison, J. (1995). *The first interview.* New York: Guilford Press.

Nader, K. O., Kriegler, J. A., Blake, D. D., Pynoos, R. S., Newman, E., & Weathers, F.W. (1996). *Clinician-Administered PTSD Scale for Children and Adolescents for (DSM-IV).* Boston, MA: National Center for PTSD, Boston Veterans Administration Medical Center.

Newman, E., McMackin, R. A., Morrissey, C., Erwin, B. A., Kaloupek, D. G., & Keane, T. M. (1998). [PTSD among incarcerated male adolescents at secure juvenile treatment facilities]. Unpublished raw data.

Nunnally, J. C. (1978) *Psychometric theory* (2nd ed.). New York: McGraw-Hill.

Pynoos, R., Rodriguez, N., Sternberg, A., Stauber, M., & Frederick, C. (1998). *UCLA PTSD Index for DSM-IV Child Version.* Los Angeles, CA: UCLA Trauma Psychiatry Service.

Reich, W. (2000). Diagnostic Interview for Children and Adolescents (DICA). *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 59-66.

Reich, W., Leacock, N., & Shanfeld, C. (1994). *Diagnostic Interview for Children and Adolescents-Revised (DICA-R)*. St. Louis, MO: Washington University.

Reynolds, C. R., & Richmond, B. O. (1985). *Revised Children's Manifest Anxiety Scale manual*. Los Angeles, CA: Western Psychological Services.

Saigh, P. A. (1989a). On the development and validation of the Children's Posttraumatic Stress Disorder Inventory. *International Journal of Special Education*, 4, 75-84.

Saigh, P. A. (1989b). The validity of the posttraumatic stress disorder classification as applied to children. *Journal of Abnormal Psychology*, 98, 189-192.

Saigh, P. A. (1992a). Structured clinical interviews and the inferential process. *Journal of School Psychology*, 30, 141-149.

Saigh, P. A. (1992b). The behavioral treatment of child and adolescent posttraumatic stress disorder. *Advances in Behaviour Research and Therapy*, 14, 247-275.

Saigh, P. A. (1998a). *Children's PTSD Inventory (DSM-IV Version)*. (Available from Philip A. Saigh, Ph.D., 365 Fifth Avenue, New York, NY 10016)

Saigh, P. A. (1998b). *Test manual for the Children's PTSD Inventory (DSM-IV Version)*. (Available from Philip A. Saigh, Ph.D., 365 Fifth Avenue, New York, NY 10016)

Saigh, P. A., & Bremner, J. D. (Eds.). (1999). *Posttraumatic stress disorder: A comprehensive text*. Needham Heights, MA: Allyn & Bacon.

Saigh, P. A., Mroueh, M., & Bremner, J. D. (1997). Academic impairments among traumatized adolescents. *Behaviour Research and Therapy*, 35, 429-436.

Saigh, P. A., Yasik, A. E., Oberfield, R. O., Halamandaris, P., Resko, J., & McHugh, M. (1999, November). Behavior ratings of children and adolescents with and without PTSD. In P. A. Saigh (Chair), *Hospital based research on child-adolescent PTSD*. Symposium conducted at the annual meeting for the International Society for Traumatic Stress Studies, Miami, FL.

Saigh, P. A., Yasik, A. E., Oberfield, R. A., Green, B., Halamandaris, P., Rubenstein, H., Nester, J., Resko, J., & McHugh, M. (2000). The Children's PTSD Inventory: Development and reliability. *Journal of Traumatic Stress*, 13, 369-380.

Saigh, P. A., Yasik, A. E., Sack, W., & Koplewicz, H. (1999). Child-adolescent posttraumatic stress disorder: Prevalence, comorbidity, and risk factors. In P.A. Saigh & J.D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive text* (pp. 19-43). Needham Heights, MA: Allyn & Bacon.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH Diagnostic Interview for Children, Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 28-38.

Shaffer, D., Lucas, C. P., & Richters, J. E. (Eds.). (1999). *Diagnostic assessment in child and adolescent psychopathology*. New York: Guilford Press.

Spielberger, C. D. (1980). *Test Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Spitzer, R. L., Endicott, J., & Robins, E. (1978). Research diagnostic criteria: Rationale and reliability. *Archives of General Psychiatry*, 23, 41-55.

Vogel, J. M., & Vernberg, E. M. (1993). Task force report part 1: Children's psychological response to disaster. *Journal of Child Clinical Psychology*, 4, 464-484.

Wolfe, V. V., Gentile, C., & Wolfe, D. A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behavior Therapy*, *20*, 215-228.

Yasik, A. E., Saigh, P. A., Oberfield, R. A., Green, B., Halamandaris, P., & McHugh, M. (2001). The validity of the Children's PTSD Inventory. *Journal of Traumatic Stress*, *14*, 81-94.

Yasik, A. E., Saigh, P. A., Oberfield, R. A., Rubenstein, H., Halamandaris, P., Nester, J., Resko, J., Koplewicz, H., Inamdar, S., & McHugh, M. (1998, November). *The reliability and validity of the Diagnostic Interview for Children and Adolescents - Revised PTSD module*. Poster presented at the annual meeting of the International Society for Traumatic Stress Studies Conference, Washington, DC.

Endnotes

[1] According to the DSM-IV (1994), PTSD is induced when a "person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (p. 427). In addition to trauma exposure, the diagnosis requires the presence of reexperiencing (e.g., nightmares or intrusive recollections regarding the incident), avoidance (e.g., efforts to avoid thoughts, activities, places, or events that are associated with the traumatic incident), increased arousal (e.g., sleep impairment, irritability, and hypervigilance) symptoms, and clinically significant distress or impairment in important areas of functioning (e.g., school, work). For a more complete description of the history, symptoms, associated features, course, etiology, and epidemiology of PTSD, the reader is referred to Saigh and Bremner's (1999) *Posttraumatic Stress Disorder: A Comprehensive Text*.

[2] *Kappa* denotes the proportion of agreement (beyond chance) that is observed between two diagnostic assessments. Fleiss (1981) indicated that a *kappa* of 0.40 is at the minimum level of acceptability. Fleiss also indicated that a *kappa* of 0.60 is considered good and *kappas* that range from 0.75 to 1.00 are very good.

[3] Internal consistency estimates provide an indication of the homogeneity of the test item content (Anastasi & Urbina, 1998). *Alpha* (Cronbach, 1951) is a widely utilized measure of internal consistency. According to the American Educational Research Association (AERA), American Psychological Association (APA), and National Council on Measurement in Education's (NCME) *Standards for Educational and Psychological Testing* (1999), "*alpha* is based on the number of parts into which the test is partitioned (e.g., items, subtests, or raters), the interrelationship of the parts, and the total test score variance" (pp. 172-173). Nunnally (1978) suggests that an *alpha* of 0.80 is adequate for research and an *alpha* of 0.90 is appropriate for diagnostic decisions.

[4] Sensitivity can be defined as the probability of receiving a diagnosis based on some assessment process if the individual truly has the disorder [e.g., true positives / (true pos-

itives + false negatives)]. As the sensitivity of a test increases, the number of false negatives will decrease. According to Hennekens and Buring (1987), “sensitivity should be increased at the expense of specificity when the penalty associated with missing a case is high” (p. 334).

[5] Specificity can be defined as the probability of receiving a negative diagnosis if the disorder is truly absent [e.g., true negatives / (true negatives + false positives)]. As the specificity of a test increases, the number of false positives will decrease (Hennekens & Buring, 1987). According to Hennekens and Buring, “specificity should be increased relative to sensitivity when the costs or risks associated with further diagnostic techniques is substantial” (p. 334).

[6] The intraclass correlation coefficient (ICC) can be utilized as a measure of reliability between two raters. Unlike the product moment correlation, the ICC takes into consideration agreement with regard to absolute ratings (Bartko & Carpenter, 1976).

[7] KR-20 coefficients, which are a special version of *alpha* appropriate for dichotomous measures, provide an indication of the internal consistency of a measure (Anastasi & Urbina, 1998).

[8] Predictive value indicates if an individual does or does not have a disorder, given the results of the assessment instrument. Positive predictive power indicates the “probability that a person actually has the disease given that he or she tests positive” [e.g., true positives / (true positives + false positives)] (Hennekens & Buring, 1987, p. 336). Negative predictive power indicates the “probability that an individual is truly disease-free given a negative screening test” [e.g., true negatives / (false negatives + true negatives)] (Hennekens & Buring, 1987, p. 337).

[9] Diagnostic efficiency refers to the overall ability of the assessment instrument to correctly classify individuals as having or not having a disorder [e.g., (true positives + true negatives) / total cases].

[10] Convergent validity is demonstrated by examining “the relationship between test scores and other measures intended to assess similar constructs” (AERA, APA, & NCME, 1999, p. 14). It is expected that measures of similar constructs should be highly associated. Discriminant validity is demonstrated by examining “"relationships between test scores and measures purportedly of different constructs” (AERA, APA, & NCME, 1999, p. 14). It is expected that measures of dissimilar constructs would be less associated than measures of similar constructs. Thus, one would expect convergent validity coefficients to be larger than those coefficients representing discriminant validity (AERA, APA, & NCME, 1999).

31

危機

The Cognitive-Behavioral Treatment of PTSD in Children and Adolescents

Philip A. Saigh, Ph.D.
City University of New York

Mariam, a 10-year-old Lebanese girl was diagnosed with posttraumatic stress disorder (PTSD). Thirty-eight months after she was exposed to an artillery barrage, she presented with trauma-related nightmares and flashbacks. She avoided the area where the incident occurred and lost interest in activities that she used to enjoy such as visiting friends. She evidenced emotional distress when exposed to loud noises and lost her temper quickly. Her sleep became impaired and her concentration was limited. Her grades deteriorated significantly. Mariam received eight 80-minute sessions of therapeutic exposure (flooding) that were followed by extensive debriefing. During the exposure sessions, her therapist asked her to imagine all of the events that she experienced during the barrage. Six months after she completed the treatment, Mariam reported that she was not experiencing trauma-reminiscent flashbacks or thoughts. She spent more time with friends, no longer experienced temper outbursts, and did not overreact to sudden noises. Her sleep and concentration were not impaired and her grade point average was consistent with her pretrauma average. Clinical evaluation determined that she no longer met criteria for PTSD.

The treatment that Mariam received is a form of cognitive-behavior therapy. Historically, different forms of cognitive-behavioral anxiety-reduction procedures have been used for hundreds of years (Saigh, Yasik, Oberfield, & Inamder, 1999). Goethe's autobiography described a successful self-initiated treatment of acrophobia (Boudewyns & Shipley, 1983). Malleson (1959) described an imaginal exposure technique to reduce the anxiety of a phobic student. Malleson reported that the student was "... classically panic stricken ... sobbing and fearful, bewailing his fate, and terrified of the impending examination ..." (p. 225). Malleson advised the student to "tell of the awful consequences that he felt would follow his failure - derision from his colleagues ... disappointment from his family and financial loss" (p. 225). Malleson also advised the student that whenever he "felt a little wave of spontaneous alarm, he was not to push it aside, but was to augment it, to try to experience it more profoundly and more vividly" (p. 225). The student complied with Malleson's instructions and reported that he was virtually unable to feel anxious as the examination date approached. He went on to pass the exam with ease.

Stampfl (1961) subsequently coined the description "implosive therapy" to characterize a treatment that "may be regarded as a synthesis between Freudian oriented and Mowerian approaches to psychotherapy" (p. 1). Stampfl and Levis (1967) developed a detailed description of the procedure as well as a rationale to account for its efficacy.[1]

Rachman (1966) went on to introduce the term "flooding" to the clinical literature. Whereas Rachman initially reported that systematic desensitization was more effective than flooding in reducing phobic reactions, he acknowledged that the subjects who were flooded received less than two minutes of therapeutic exposure at a time and that it was "possible therefore that the crucial element omitted in the present technique is prolonged exposure" (p. 6). Following the initial reports by Stampfl (1961), Stampfl and Levis (1967), and Rachman (1966), a host of studies involving longer intervals of therapeutic exposure were conducted (e.g., Hogan & Kirchner, 1967; Levis & Carrera, 1967). Unlike the Rachman (1966) investigation, these studies reported efficacy across a variety of phobic samples.

Flooding Traumatized Individuals

Given the efficacy of flooding procedures with simple and social phobics, Fairbank, DeGood, and Jenkins (1981) used a multifaceted flooding package in the treatment of a 32-year-old female survivor of a motor vehicle collision. Although the woman recovered from her injuries and was able to drive, she experienced panic attacks whenever she attempted to drive. Using directed relaxation, self-monitoring, and imaginal exposure, Fairbank et al. eliminated the startle reaction and appreciably reduced her self-rated anxiety estimates after five treatment sessions. These gains continued to be evident at one-, four-, and six-month follow-ups.

Keane and Kaloupek (1982) went on to publish a report on "imaginal flooding in the treatment of posttraumatic stress disorder" (p. 138). The article involved the treatment of a 36-year-old male Vietnam veteran with war-related PTSD [American Psychiatric Association (APA), 1980]. Keane and Kaloupek identified traumatic reexperiences in the form of highly arousing thoughts and nightmares. The patient was instructed to imagine the traumatic events during nineteen 40-minute treatment sessions. Keane and Kaloupek reported significant reductions in self-reported anxiety as well as improved sleep and work-related efficacy. Follow-up assessments denoted efficacy at 3- and 12-month follow-ups.

Child-Adolescent PTSD Studies Employing Single-Case Research Designs

Given the absence of information involving the effects of flooding with traumatized youths and the clinical need to provide services for traumatized youths during the Lebanese war, Saigh carried out a number of single-case flooding trials at the American University of Beirut Medical Center. Initially, Saigh (1987a) described the treatment of a 14-year-old Lebanese boy who had been abducted by a militia group. Six months after the incident, the boy met criteria for PTSD as measured by the Children's PTSD Inventory (Saigh, 1989a[2]). A 12-item Behavioral Avoidance Test (BAT) was developed in order to quantify aspects of his trauma-related avoidance behaviors. The BAT involved a 10-minute behavioral walk wherein the boy left his home and followed the route that he had previously taken to the location where the abduction occurred. As the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III; APA, 1980) indicates that PTSD is indicated in part by deficits in short-term memory and concentration, the WISC-R Coding and Digit Span subtests were administered. The boy also marked the State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushane, 1968), the Rathus Assertiveness Schedule (RAS; Rathus, 1973), and the Beck Depression Inventory (BDI; Beck, Ward, Mandelson, Mock, & Erbaugh, 1961).

The parents and child were educated about the nature and course of PTSD, the flooding process, short-term reactivity, and the importance of securing accurate assessments before, during, and following treatment. After obtaining their informed consent, Saigh conducted a series of clinical interviews to identify four anxiety-evoking scenes. These scenes reflected the sequence of traumatic events that the youths had experienced (e.g., being stopped, forced into a car at gunpoint, blindfolded, and driven away). The flooding regimen involved 10 minutes of therapist-directed deep muscle relaxation exercises. These were followed by 60 minutes of therapeutic stimulation during which the youth was advised to imagine the contents of the anxiety-evoking scenes according to a multiple-baseline across traumatic scenes design. Emotional discomfort relative to the traumatic scenes was measured through subjective units of disturbance (SUDs) ratings. In so doing, the youth rated each scene according to a 0-10 point scale with 0 denoting "no discomfort" and 10 denoting "maximum discomfort." SUDs ratings were recorded at two-minute intervals during each scene presentation. Debriefing was provided following each treatment session.

Following seven exposure sessions, SUDs levels decreased appreciably. A four-month follow-up determined that the youth reported almost no distress as denoted by his SUDs ratings. Clinically significant posttreatment gains were apparent on his WISC-R Coding and Digit Span performance. Posttreatment and four-month follow-up assessments also reflected treatment gains relative to self-reported anxiety, depression, and aggression. Whereas the youth completed one-third of the BAT activities before the treatment, he performed 100% of the BAT activities after the final treatment session. These gains also were maintained at the four-month follow-up evaluation.

Table 1

Case Example of the Imaginal Flooding Process With a 10-Year-Old Female

Therapist 1:	Imagine that you are playing in a neighborhood garden in the afternoon. Imagine the color of the grass and the plants. Imagine the people slowly walking by. Can you picture this?
Mariam 1:	Yes.
Therapist 2:	Imagine running after the ball that your mother threw. Now, imagine that you are looking at the shrubs. Imagine how you are separating the shrubs in search of the ball. Can you imagine yourself doing this?
Mariam 2:	Yes.
Therapist 3:	Now I want you to keep on imagining that you are leafing through the shrubs. Imagine the texture of the shrubs against your hands. Imagine the color of the underside of the leaves. Can you imagine this?
Mariam 3:	Yes.
Therapist 4:	According to the scale that we discussed, how much does this bother you?
Mariam 4:	Seven.
Therapist 5:	Very good. Keep on picturing this. (10-second pause). Now imagine that you can hear loud noises that sound like thunder in the distance as you are looking for the ball. Can you imagine these noises?
Mariam 5:	Yes.
Therapist 6:	Good. Now I want you to imagine that you are still looking for the ball in the shrubs. (10-second pause). Suddenly, you hear a very loud explosion nearby. Imagine that you are looking up. People are running away. Imagine how everyone is running. Can you do this?
Mariam 7:	Yes.
Therapist 8:	How much does it bother you?
Mariam 8:	Ten.
Therapist 9:	Keep on imagining how people are running away. Imagine that you are turning away from the shrub. You want to find your mother. Imagine looking at the place where your mother had been. She is not there. Imagine that you suddenly hear a very loud explosion. Imagine that you are starting to run to the place where your mother had been. Can you picture this?
Mariam 9:	Yes. It's very bad.
Therapist 10:	How disturbing is it?
Mariam 10:	Ten.

Note

Table 1 presents the transcript of a flooding session involving a 10-year-old Lebanese female who developed PTSD after being exposed to an artillery barrage (Saigh, 1987b). As may be noted from the table, stimulus and response imagery cues (Levis, 1980) were employed during the flooding process. Stimulus cues involved the visual, auditory, olfactory, and tactile components of each scene. Response cues involved the behavioral and cognitive aspects of the scene. In addition to imaginal flooding, the treatment package involved education regarding PTSD and the flooding process, relaxation training, and debriefing.

Given the observed efficacy, Saigh (1987b, 1987c, 1987d, 1989b) conducted four single-case replications wherein flooding was used in the treatment of child-adolescent PTSD. In each instance, traumatic scenes were identified and presented according to a multiple-baseline across traumatic scenes design. Stimulus and response imagery cues were employed during the flooding process. Stimulus cues involved the visual, auditory, tactile, and olfactory components of each scene. Response cues involved the behavioral and cognitive aspects of the scene. Table 1 presents a transcript from one of the flooding sessions that 10-year-old Mariam received after developing war-related PTSD.

The number of intrusive trauma-related thoughts (excluding those that were induced in therapy) were self-monitored on pocket frequency counters (i.e., the Knit Tally, Boyle Needle Company) in two of the Lebanese reports (Saigh, 1987b, 1987c). The frequency of spontaneous trauma-related thoughts was initially self-monitored by Mariam (Saigh, 1987b). Imaginal flooding apparently induced a brief exacerbation of intrusive trauma-related thoughts. It is also apparent that the frequency of self-reported traumatic memories decreased appreciably over time. Comparable patterns of distress and habituation were observed in a follow-up study involving three Lebanese children with war-related PTSD (Saigh, 1987c).

Pre- and posttreatment gains were observed on the WISC-R Digit Span and Coding subtests in all of the Saigh single-case treatment studies. In a similar vein, reductions in self-reported reactivity to the traumatic scenes were evident on the SUDs ratings that were monitored before therapy, during therapy, at posttreatment, and at follow-up assessments. Appreciable reductions were observed across self-report measures of anxiety and depression. Four of the Lebanese child-adolescent reports (Saigh, 1987a, 1987b, 1987c, 1989b) included performance measures. Appreciably less avoidance was evident as denoted by BAT performance at posttreatment and follow-up assessments. The participants' comments supported the social validity (Wolf, 1978) of the interventions because they indicated that the treatment outcome was worth the temporary discomfort.

More recently, Cocco and Sharpe (1993) employed an auditory variant of eye movement desensitization and reprocessing (EMDR; Shapiro, 1989) in the treatment of a four-year, nine-month-old Australian male assault victim. Typically, EMDR involves asking patients to imagine trauma-related stimuli while visually tracking the finger movements of a therapist and articulating negative and positive self-referent cognitions. As based on parent and child self-reports (the use of a structured clinical interview was not reported), the youth met criteria for PTSD. Cocco and Sharpe reported that the youth had been experiencing nightmares, sleeping in his parents' bed, wetting his bed, asking for reassurance, talking about the incident, and carrying a toy gun since the assault. It was also indicated that these problems had been evident for one year.

Cocco and Sharpe reported that the boy was not able to simultaneously imagine the traumatic event and track the therapist's finger movements. In lieu of the standard

EMDR regimen, the boy was asked to draw a picture of the assailants and a picture of a super hero. The youth was subsequently instructed to look at the picture of the assailants and think about the traumatic event as the therapist clicked his fingers at a rate of 4 clicks per second for 12 seconds. The boy was subsequently asked to look at the picture of the super hero and verbalize what the hero was going to do to the assailants. The boy was then asked to look at both pictures and imagine how the hero was attacking the assailant as a therapist clicked his fingers. The therapist employed the auditory clicking procedure as the youth was engaged in this process. The authors represented that after 14 clicks, the boy independently began to stab the picture of the assailants with a felt pen and declared "They're dead ... they're dead" (p. 375). Cocco and Sharpe reported that 48 clicks were presented as the youth stabbed the picture and verbalized.

The authors also reported that the boy did not evidence nightmares, seek reassurance, wet his bed, sleep with his parents, or carry a toy gun immediately after treatment. Treatment gains relative to nightmares, reassurance, and the carrying of the toy gun reportedly were maintained at three- and six-month follow-ups. On the other hand, three- and six-month follow-up data revealed that the frequency of bed-wetting and sleeping in the parent's bed reverted to pretreatment levels.

Examined comprehensively, the Lebanese multiple baseline child-adolescent treatment studies clearly denoted efficacy across a host of outcome measures. It should also be noted that these trials were not limited to exposure; participants received a multifaceted treatment package that included: (a) parent-child education regarding PTSD, (b) education regarding the flooding process, (c) relaxation training, (d) prolonged imaginal exposure (flooding), and (e) debriefing. All of the Lebanese single-case studies involved youths who had been symptomatic for at least one year, and rapid improvement was reported (following 8 to 15 treatment sessions). Although these studies clearly denoted efficacy across a number of participants and measures, information pertaining to treatment integrity (i.e., evidence that treatment was implemented as specified in the reports) was not reported. It may also be said that single-case designs do not afford the same level of external validity as true experimental designs.

As in the case of the Lebanese reports, the modified EMDR Australian study denoted treatment gains over time. Although PTSD had been evident for more than a year, rapid gains were reported following a single treatment session. On the other hand, information regarding treatment integrity was not reported. It should also be noted that Cocco and Sharpe employed a reversal design, and that these series do not afford the same level of external validity as experimental designs.

To date, EMDR has been primarily used in the treatment of adult PTSD and other psychiatric disorders (Singer & Lalich, 1996) with reported success by a number of investigators (e.g., Shapiro, 1995; Wilson, Becker, & Tinker, 1995). Despite the reported efficacy of the modified EMDR regimen as indicated by Cocco and Sharpe (1993), information pertaining to the use of this approach in the treatment of child-adolescent PTSD is limited. It should also be noted that cognitive-behavioral investigators have reported that: (a) the effects of EMDR are largely or totally limited to verbal reports (Lohr, Tolin, & Lilienfeld, 1998; Rosen, 1999); (b) eye movements appear to be unnecessary for improvement (Boudewyns & Hyer, 1996; Lohr, Lilienfeld, Tolin, & Herbert, 1998; Lohr et al., 1998; Pittman et al., 1996); and (c) the reported EMDR effects are consistent with nonspecific procedural artifacts (Lohr et al., 1998[1]). Given these concerns, mental health professionals should review the EMDR literature and employ scientific reasoning to formulate conclusions about the efficacy of the modality.

Child-Adolescent PTSD Studies Employing Quasi-Experimental Designs

Deblinger, McLeer, and Henry (1990) employed clinical interviews and the Schedule for Affective Disorders and Schizophrenia for School Age Children Epidemiological Version (K-SADS-E; Puig-Antich, Orvaschel, Tabrinzi, & Chambers, 1980) to identify 19 female child abuse victims (age range 3 to 16 years) with PTSD. Deblinger and her colleagues (1990) presented a multifaceted child intervention that involved modeling coping skills, gradual exposure, and sexual abuse education. Participants were allowed to select the type of exposure procedure that they preferred (e.g., confronting abuse-related issues through a choice of imagery, doll play, drawing, reading, or singing). The child participants received 10 treatment sessions (duration was not reported). The authors also provided treatment for the nonoffending parents. This treatment involved child abuse education, training in child-parent communication, and the use of behavior management skills. Deblinger et al. reported that none of the participants met DSM-III-R (APA, 1987) criteria for PTSD after they completed the treatment. They also reported significant reductions over baseline assessments on the total index of an earlier version of the Children's Depression Inventory (CDI; Kovacs, 1992), the State-Trait Anxiety Inventory for Children (Spielberger, 1973), and the Internalizing and Externalizing indices of the Child Behavior Checklist (CBCL; Achenbach, 1991).

March, Amaya-Jackson, Murray, and Schulte (1998) used the Clinician Administered PTSD Scale-Child and Adolescent Version (CAPS-CA; Nader, Blake, Kriegler &, Pynoos, 1994) to screen 1,800 children at two elementary schools and two junior high schools. Seventeen youths (age range 10 to 15 years) were judged to be suitable for treatment. Ten of the 17 participants experienced two or more traumatic incidents, and none had a positive history for abuse. Examples of the stressors reported were motor vehicle accidents, accidental injury, gun shot, and fire-related injuries. Inclusion criteria consisted of a PTSD diagnosis as denoted by the CAPS-CA and "motivation to work on PTSD as an identified problem, general cognitive abilities, and social problem-solving skills" (p. 586). Participants received 18 multifaceted treatment sessions. Session duration was approximately 50 minutes. These sessions involved (a) goal setting, (b) an explanation of how the treatment was going to be applied in group settings, (c) anxiety-management training, (d) guided muscle relaxation, (e) generation of distress ratings through the use of a "fear thermometer", (f) anger-management training, (g) positive self-talk, (h) construction of trauma-specific fear hierarchies, (i) corrective information regarding trauma-specific attributions, and (j) imaginal exposure to traumatic material.

March and his colleagues (1998) reported that 14 of the 17 participants completed the treatment. Of these, 8 (57%) no longer met DSM-IV (APA, 1994) criteria for PTSD as measured by the CAPS-CA immediately after their regimen was completed and 12 (86%) were free of PTSD at a six-month follow-up. Significant reductions in PTSD symptoms were also evident on the Child and Adolescent Trauma Survey (March & Amaya-Jackson, 1998) immediately after the treatment was completed and at a six-month follow-up. Significantly lower posttreatment and follow-up scores were observed on the Clinical Global Improvement Scale (Guy, 1976), Conners Teacher Rating Scale (Conners, 1995), Multidimensional Anxiety Scale for Children (March, Parker, Sullivan, Stallings, & Conners, 1997), Children's Depression Inventory (Kovacs, 1992), and the State Trait Anger Expression Inventory (Spielberger, 1988). Nonsignificant variations were reported on the Nowicki and Strickland (1973) locus of control index.

Although the quasi-experimental results are promising, a number of limitations are apparent. The Deblinger et al. (1990) and March et al. (1998) investigations did not report information regarding the interval between assessment and intervention. As control groups were not employed and as the child-adolescent PTSD epidemiological literature indicates that the prevalence of the disorder decreases over time (Saigh, 1988; Saigh, Yasik, Sack, & Koplewicz, 1999), the results may have occurred as a function of spontaneous remission. It is also to be noted that none of the quasi-experimental studies offered empirical information regarding treatment integrity. Moreover, the quasi-experimental studies presented multifaceted treatment packages, and the efficacy of the independent components of these elements was not established with PTSD cases. In addition, the Deblinger et al. (1990) study did not present the same treatment to all of the participants, and the procedural variance greatly limits the external validity of the findings. It is also important to realize that quasi-experimental research designs do not provide the same degree of external validity as true experimental designs (Saigh et al., 1999) and the generalizabilty of these findings must be tempered accordingly. Despite these reservations, the quasi-experimental studies denoted efficacy across a number of treatment outcome measures and participants.

Child-Adolescent PTSD Research Employing an Experimental Design

To date, a single experimental study has examined the effects of a cognitive-behavioral treatment package with a sample of traumatized youths. Deblinger, Lippmann, and Steer (1996) randomly assigned 100 sexually abused children between the ages of 7 to 13 years to one of four treatment groups (i.e., standard community care, child intervention, nonoffending parent intervention, and combined child and parent intervention). The authors reported that 71% of the sample met DSM-III-R criteria for PTSD as based on K-SADS-E diagnoses.

In the community control condition, parents were offered information about their children's symptom patterns and urged to seek therapy. Participants in the child intervention condition were provided with training involving: (a) relaxation procedures, (b) emotional expression skills, (c) cognitive coping skills, and (d) abuse education. In addition, each participant was offered a choice of different exposure modalities such as (a) abuse-related doll play, (b) discussion, (c) reading, or (d) singing.

In the parent regimen, therapists "accepted and validated mothers' experiences and corrected common misconceptions that might have given rise to their heightened negative emotional reactions" (Deblinger et al., 1996, p. 315). Parents also received training involving how to discuss issues related to sexual abuse and sexuality in general with their children. In addition, parents were trained in the use of behavior-management skills. Participants in the combined child and parent intervention group received the child and parent interventions.

Deblinger et al. (1996) reported that the children who received the child and combined child and parent interventions had significantly fewer PTSD symptoms after the treatment was completed than the participants in the parent or community interventions. They reported that the mothers who were assigned to the parent training group and the mothers in the combined child-parent group reported significantly greater use of parenting skills as measured by the Parent Practices Questionnaire (Strayhorn & Weidman, 1988). The authors reported that mothers assigned to the child-parent and parent groups rated their offspring as exhibiting significantly lower externalizing ratings on the CBCL Externalizing scale relative to the ratings of the child and community groups. Information regarding CBCL variations between the former groups was not presented. Participants in the child as well as the child-parent conditions reported significantly lower CDI scores than the participants in the child or community groups. Comparative differences between the child and child-parent groups were not explored.

While the findings denote efficacy between the comparisons that were performed, a number of major concerns are apparent. Although the authors reported that they used a treatment manual, they did not report data to support the integrity of the treatment. Given that a number of treatment components were presented, the failure to document treatment integrity presents a serious threat to the validity of the study. Information involving potential differences between the child and the combined child-parent interventions was not addressed. Finally, the findings are difficult to interpret because of the unsystematic way that the treatment was applied within the experimental groups (i.e., participants did not receive the same treatment).

Ethical Considerations

Given that therapeutic exposure procedures were employed by all of the child-adolescent cognitive-behavioral investigations and because exposure is an aversive procedure, the rights of children and adolescents should be protected. Child participants and their parents should be informed about the procedures that will be used. They should also be advised that these procedures may induce situational reactivity during the early stages of intervention. Certainly, the informed consent of children-adolescents and their parents should be obtained before flooding is attempted.

The ethical guidelines of the Association for the Advancement of Behavior Therapy (AABT, 1977) should be employed as they provide operational recommendations for clinical practice and as they address issues that are relevant to the needs of school-age populations. These guidelines maintain that therapists should determine if participation is truly voluntary by considering possible sources of coercion. Therapists should also ensure that participants are aware that they may withdraw from treatment at any time without reprimand. When the competence of a child or adolescent is limited, the guidelines indicate that efforts should be made to ensure that the "client as well as the guardian participate in treatment discussions to the extent that the client's ability permits" (p. vi). The AABT guidelines indicate that an understanding of the treatment goals should be corroborated by asking the patient to restate the goals either verbally or in writing. Because epidemiological research indicates that PTSD may remit over time (Saigh, 1988; Saigh, Green, & Korol, 1996; Saigh et al., 1999), therapists may wish to consider the time-limited use of supportive counseling or anxiolytic medications with youths who meet criteria for PTSD shortly after traumatization.

Conclusions and Future Directions

Examined *in toto*, the child-adolescent single-case, quasi-experimental, and experimental trials speak well for the efficacy of cognitive-behavioral interventions. Indeed, cognitive-behavioral regimens effectively reduced PTSD symptoms and a number of the associated features of the disorder. On the other hand, it may also be said that additional research must be conducted before more definitive conclusions can be reached. Research designed to identify child-adolescent PTSD patient, therapist, treatment, and family factors that are associated with successful outcomes is clearly in order. Researchers should identify child-adolescent factors that are associated with treatment efficacy (e.g., age, ability to imagine, the quality of visual imagery, the ability to follow instruction, threshold for fatigue, and the ability to relax). There is also a need to identify co-morbid disorders (e.g., substance abuse, conduct disorder, or attention deficit hyperactivity disorder) that may influence therapeutic outcomes. Likewise, the influence of moderator variables, such as the quality of therapeutic relationships and the qualitative aspects of parental support, warrant systematic examination. Given that all of the cognitive-behavioral interventions employed multifaceted treatment packages, there is a clear need to conduct dismantling studies to identify the efficacy of the various treatment components. Finally, investigators should demonstrate the integrity of these treatments as all of the studies that were reviewed did not control for this form of variance.

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Association for the Advancement of Behavior Therapy. (1977). Ethical issues for human services. *Behavior Therapy*, *8*, v-vi.

Beck, A. T., Ward, C. H., Mandelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561-571.

Boudewyns, P. A., & Hyer, L. A. (1996). Eye movement desensitization and reprocessing (EMDR) as treatment for posttraumatic stress disorder (PTSD). *Clinical Psychology and Psychotherapy*, *3*, 185-195.

Boudewyns, P. A., & Shipley, R. H. (1983). *Flooding and implosive therapy*. New York: Plenum Press.

Cocco, N., & Sharpe, L. (1993). An auditory variant of eye-movement desensitization in a case of childhood posttraumatic stress disorder. *Journal of Behaviour Therapy and Experimental Psychiatry*, *24*, 373-377.

Conners, C. (1995). *Conners' Rating Scales*. Toronto, Ontario: Multi-Health Systems.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, *1*, 310-321.

Deblinger, E., McLeer, S. V., & Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering from post-traumatic stress: Preliminary findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, *29*, 747-752.

Fairbank, J. A., DeGood, D. D., & Jenkins, C. W. (1981). Behavioral treatment of a persistent post-traumatic startle response. *Journal of Behavior Therapy and Experimental Psychiatry*, *12*, 321-324.

Guy, W. (1976). *ECDEU Assessment manual for psychopharmacology*. (DHEW Publication ABM 76-388). Washington, DC: US Government Printing Office.

Hogan, R. A., & Kirchner, J. H. (1967). Preliminary report on the extinction of learned fears via short term therapy. *Journal of Abnormal Psychology*, *72*, 106-109.

Keane, T. M., & Kaloupek, D. G. (1982). Imaginal flooding in the treatment of posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *50*, 138-140.

Kovacs, M. (1992). *The Children's Depression Inventory*. North Tonowanda, NY: Multi-Health Systems.

Levis, D. J. (1980). Implementing the technique of implosive therapy. In A. Goldstein & E. Foa (Eds.), *Handbook of behavioral interventions: A clinical guide* (pp. 51-92). New York: Wiley.

Levis, D. J., & Carrera, R. N. (1967). Effects of ten hours of implosive therapy in the treatment of outpatients: A preliminary report. *Journal of Abnormal Psychology, 72*, 504-508.

Lohr, J. M., Lilienfeld, S. O., Tolin, D. F., & Herbert, J. D. (1999). Eye movement desensitization and reprocessing: An analysis of specific versus nonspecific treatment factors. *Journal of Anxiety Disorders, 13*, 185-207.

Lohr, J. M., Tolin, D. F., & Lilienfeld, S. O. (1998). Efficacy of eye movement desensitization and reprocessing: Implications for behavior therapy. *Behavior Therapy, 29*, 123-156.

Malleson, N. (1959). Panic and phobia: A possible method of treatment. *Lancet, 1*, 225-227.

March, J. S., & Amaya-Jackson, L. (1998). *Child and Adolescent Trauma Survey.* Duke University Medical Center, Department of Psychiatry.

March, J. S., Amaya-Jackson, L., Murray, M. A., & Schulte, A. (1998). Cognitive-behavioral psychotherapy for children and adolescents with posttraumatic stress disorder after a single incident stressor. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 585-593.

March, J. S., Parker, J., Sullivan, K., Stallings, P., & Conners, C. (1997). The Multidimensional Anxiety Scale for Children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 554-565.

Nader, K., Blake, D., Kriegler, J., & Pynoos, R. (1994). *Clinician Administered PTSD Scale for Children (CAPS-C), Current and Lifetime Diagnosis Version and Instructional Manual.* UCLA Neuropsychiatric Institute, Los Angeles, CA, and National Center for PTSD, Boston, MA.

Nowicki, S., & Strickland, B. (1973). A locus of control scale for children. *Journal of Consulting and Clinical Psychology, 40*, 148-154.

Pittman, R. K., Orr, S. P., Altman, B., Longree, R., Poire, R., & Maclin, M. (1996). Emotional processing during eye movement desensitization and reprocessing therapy of Vietnam veterans with chronic posttraumatic stress disorder. *Comprehensive Psychiatry, 37*, 419-429.

Puig-Antich, J., Orvaschel, H., Tabrinzi, M. H., & Chambers, W. (1980). *The Schedule for Affective Disorders and Schizophrenia for School Age Children Epidemiological Version (Kiddie SADS-E).* New York Psychiatric Institute, New York, NY, and Yale University School of Medicine, New Haven, CT.

Rachman, S. J. (1966). Studies in desensitization - II: Flooding. *Behaviour Research and Therapy, 4*, 1-6.

Rathus, S. A. (1973). A 30-item schedule for assessing assertive behavior. *Behavior Therapy, 4*, 398-406.

Rosen, G. M. (1999). Treatment fidelity and research on eye movement desensitization and reprocessing (EMDR). *Journal of Anxiety Disorders, 13*, 173-184.

Saigh, P. A. (1987a). *In vitro* flooding of an adolescent's posttraumatic stress disorder. *Journal of Clinical Child Psychology, 16*, 147-150.

Saigh, P. A. (1987b). *In vitro* flooding of a childhood posttraumatic stress disorder. *School Psychology Review, 16*, 203-211.

Saigh, P. A. (1987c). *In vitro* flooding of childhood posttraumatic stress disorder: A systematic replication. *Professional School Psychology, 2*, 133-145.

Saigh, P. A. (1987d). *In vitro* flooding of a 6-year-old boy's posttraumatic stress disorder. *Behaviour Research and Therapy, 24*, 685-689.

Saigh, P. A. (1988). Anxiety, depression, and assertion across alternating intervals of stress. *Journal of Abnormal Psychology, 97*, 338-342.

Saigh, P. A. (1989a). The development and validation of the Children's Posttraumatic Stress Disorder Inventory. *International Journal of Special Education, 4*, 75-84.

Saigh, P. A. (1989b). The use of *in vitro* flooding in the treatment of traumatized adolescents. *Journal of Behavioral and Developmental Pediatrics, 10*, 17-21.

Saigh, P. A., Green, B., & Korol, M. (1996). The history and prevalence of posttraumatic stress disorder in children and adolescents. *Journal of School Psychology, 34*, 107-132.

Saigh, P. A., Yasik, A. E., Oberfield, R., & Inamder, S. (1999). Behavioral treatment of traumatized youth. In P. A. Saigh & J. D. Bremner (Eds.), *Posttraumatic stress disorder: A comprehensive text* (pp. 354-375). Needham Heights, MA: Allyn & Bacon.

Saigh, P. A., Yasik, A., Sack, W., & Koplewicz, H. (1999). Child-adolescent posttraumatic stress disorder: Prevalence, comorbidity, and risk factors: In P. A. Saigh & J. D. Bremner (Eds.) *Posttraumatic stress disorder: A comprehensive text* (pp. 19-43). Needham Heights, MA: Allyn & Bacon.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2*, 199-223.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.

Singer, M. T., & Lalich, J. (1996). *"Crazy" therapies: What are they? Do they work?* San Francisco, CA: Jossey-Bass.

Spielberger, C. D. (1973). *Manual for the State-Trait Anxiety Inventory for Children*. Palo Alto, CA: Consulting Psychologist Press.

Spielberger, C. D. (1988). *State-Trait Anger Expression Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.

Spielberger, C. D., Gorsuch, R. L., & Lushane, R. E. (1968). *Manual for the State Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologist Press.

Stampfl, T. G. (1961). *Implosive therapy: A learning theory derived psychodynamic technique*. Unpublished manuscript, John Carroll University, Cleveland, OH.

Stampfl, T. G., & Levis, D. J. (1967). Essentials of implosive therapy: A learning-based psychodynamic behavioral therapy. *Journal of Abnormal Psychology, 72*, 496-503.

Strayhorn, J. M., & Weidman, C. S. (1988). A parent practices scale and its relation to parent and child mental health. *Journal of the American Academy of Child & Adolescent Psychiatry, 27*, 613-618.

Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology, 63*, 928-937.

Wolf, M. M. (1978). Social validity: The case of subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11*, 315-329.

Endnotes

[1] Stampfl and Levis (1967) maintained that the first objective of implosive therapy is to identify the exteroceptive and interoceptive conditioned stimuli (cues) that phobic patients avoid. They proposed that fear-evoking cues occur in a variety of forms (e.g., cognitive, auditory, and tactile). It was further proposed that these cues are interdependent and arranged in a serial hierarchy relative to the extent that they are feared (avoided). Working with this rationale, cues are selected from patient experiences wherein "objects or situations are known to have high-anxiety eliciting value, as in specific traumatic situations, material produced by dreams or symbolism of a psychoanalytic nature" (p. 502). Once identified, cues are sequentially presented by asking patients to imagine and verbalize symptom contingent cues until extinction occurs.

[2] The Children's PTSD Inventory was developed in 1982, and information regarding its psychometric properties was published in 1989. This instrument reflected the diagnostic criteria for PTSD as indicated in the third edition of the APA's (1980) *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*.

[3] Lohr et al.'s (1998) analysis of the EMDR literature indicated that "when compared with control procedures that control for nonspecific effects (closed eye imagery, blinking light, or finger snapping), the comparative benefits of EMDR have not been established" (p. 135).

32

危機

Children's Grief

Alan D. Wolfelt, Ph.D.
Center for Loss and Life Transition (Fort Collins, CO)

Children grieve when someone they love or someone in their school community dies. Grief is the constellation of thoughts and feelings the bereaved child experiences following the death. For bereaved children to heal, they must be taught and encouraged to mourn and to express their grief outside themselves.

This chapter, in addition to touching on the nature of childhood grief following sudden, traumatic death, addresses the mourning needs of all grieving children, whether they are affected by the timely or untimely death of a family member, neighbor, friend, teacher, or schoolmate. Compassionate school-based helpers may be one of the bereaved child's major supporters. The intent of this chapter is to provide information on childhood grief that will help educational professionals be better companions and helpers to grieving students.

Sudden, Traumatic Death

Unfortunately, today's children are exposed to violent deaths in many forms. They have been taught, through the media and through the realities of their day-to-day lives, that people die. That people sometimes kill other people. That people sometimes kill themselves. That people take drugs or alcohol and then drive, sometimes killing others. When children are personally impacted by sudden or accidental death, homicide, or suicide, they are *not* often taught about their unique grief and its healthy expression. You can help by understanding the special needs of survivors of sudden and traumatic death.

Sudden, traumatic deaths often leave survivors feeling numb and shocked for weeks and even months (McCann & Pearlman, 1990; van der Kolk & Saporta, 1991). Whether the death was natural (as in a teacher's heart attack) or accidental (as in a car crash), the bereaved child will probably have a hard time acknowledging the reality of the death (Crenshaw, 1990). The child will probably need extra support in the first weeks and months following the death (Webb, 1993; Wolfelt, 1983, 1996).

Homicide

Death by homicide also creates overwhelming grief for survivors. Murder results in survivors grieving not only the death, but also how the person died. A life has been cut short through an act of cruelty. The disregard for human life adds overwhelming feelings of turmoil, distrust, injustice, and helplessness to the child's normal sense of loss and sorrow (Rando, 1993). Survivors of murder victims enter into a world that is not understood by most people. A sad reality is that members of a community where a tragic murder has occurred sometimes blame the victim or survivors. Out of a need to protect themselves from their own feelings of vulnerability, some people reason that the murder has to be somebody's fault.

Suicide

Death by suicide is stigmatized in our society (Doka, 1989; Stillion, 1996). In general we believe that suicide is wrong, and talking about it makes us uncomfortable. If a child's father dies of a heart attack or is killed in a random shooting, the child may receive loving support from those around him or her. But if the child's father completes suicide, the child may be left to grieve in isolation. Research suggests that suicide-bereaved children are likely to experience many naturally occurring symptoms of complicated mourning (Brent et al., 1994; Cerel, Fristad, Weller, & Weller, 1999). A child's grief following a sudden, traumatic death is always complex. Do not be surprised by the intensity of feelings. Accept that the child may be struggling with a multitude of emotions more intense than those experienced after other types of death. Confusion, disorganization, fear, vulnerability, guilt, or anger are just a few of the emotions survivors may feel (Brent et al., 1994).

A child survivor of sudden or violent death may also feel intense anger. In my experience, the child's sense of injustice about the nature of the death turns the normal anger of grief into rage. Remember—anger is not right or wrong, good or bad, appropriate or inappropriate. Do not try to diminish the anger, for it is in expressing rage that it begins to lose some of its power. Ultimately, healthy grief requires that these explosive emotions be expressed, not repressed (Wolfelt, 1996).

Feelings of anxiety, panic, and fear are also normal (Lehmann, Jimerson, & Gaasch, 2001; Wolfelt, 1996). The child may feel threatened and unprotected. The world no longer feels as safe as it once did. Fear of what the future holds, fear that more sudden deaths might occur, an increased awareness of one's own mortality, feelings of vulnerability about being able to survive without the person, an inability to concentrate, and emotional and physical fatigue all serve to heighten anxiety, panic, and fear.

The unanswerable question, "But, why?" naturally comes up for survivors of a traumatic, violent death. The bereaved child is searching to understand how something like this could happen. This doesn't mean you must answer the "why?" question. Bereaved children need a safe place to think, talk, and play out their feelings about this question more than they need a pat answer.

Multiple Loss and the Bereaved Child

When a child is confronted with multiple deaths (the deaths of two or more significant people in the same event, or the sequential deaths of two or more significant people within a relatively short time period), the child's bereavement may be naturally complicated. The child will face many challenges, including: How do I begin to mourn? Can I mourn these deaths all at once? Whom do I mourn first? Can I trust enough to allow myself to love again?

Other manifestations of complicated mourning resulting from multiple loss include overwhelming, unbearable pain, lack of support if more than one primary caregiver dies, potential survivor guilt ("Why am *I* still alive?"), and a natural resistance to undertake the work of mourning. If, over time, children are not compassionately companioned through their complicated mourning journeys, they are at risk for behavioral and emotional problems (Worden, 1996).

So how best to care for children who have experienced multiple loss? In my experience, what these children need most is to be very slowly helped to mourn and to trust in the world again. Expect more intense, more lasting grief in these children. You might also see more extensive acting-out and long-term complications with attachment. Be patient, firm, and compassionate.

Gender and Grief

This influence on grief stems from the different ways in which boys and girls are taught to express their feelings. Generally, boys are encouraged to be strong and exercise restraint in expressing painful feelings. Because of this, boys often have more difficulty in allowing themselves to feel helpless and express their grief (Silverman & Worden, 1992). Girls, too, may encounter socially engendered difficulties in expressing their grief. While they may have been taught to show sadness, they are often also taught that for them, anger is bad—especially physical expression of that anger. Thus, girls sometimes repress appropriate grief-borne anger.

We as caregivers must stay sensitive to this gender conditioning. Unfortunately, we cannot control how children already have been conditioned, but we can help them express those feelings they sometimes feel ashamed to have. For example, you might encourage both boys and girls to release pent-up emotions by engaging in physical activities.

Availability of Support Systems

Another factor influencing a child's grief is the support system (Wolfelt, 1996). Some unfortunate children literally do not have a support system. Most often these children are from homes in which the adults have not been emotionally available to them. When bereaved children do have familial support systems, this does not automatically mean family members help them with the work of mourning. Some families have a closed family system that doesn't allow members to talk openly about death (Shapiro, 1994). In these homes, the stated or unstated rules about death are: we take down photos of the dead person, we don't allow children to go to funerals, and we don't talk about the person who died.

At the other end of the spectrum are more fortunate children who are surrounded by loving adults who encourage them to talk openly about their grief. These bereaved children are invited to participate in the funeral or other rituals, are encouraged to remember the person who died, and are able to ask questions about death without feeling shame or embarrassment.

The availability of support systems to the bereaved child is only half the story. The capacity to make use of that support is the other half. In my experience, younger children are generally more responsive to support. Caring adults will generally find their efforts well received if they make themselves available to young children. As children get older, though, especially when they enter adolescence, they sometimes find it hard to accept help. Their primary developmental task—separating from their parents and other adult caregivers—runs contrary to seeking help from these same people.

Finally, children tend to imitate what goes on around them. If the adults in their lives model healthy support-seeking behaviors, the bereaved child will most likely do the same. On the other hand, if the bereaved child's parents tend not to seek out or accept help from others in times of need, the child will not either.

Physical Health

A holistic understanding of the child requires awareness of the child's physical condition. An excellent standard of care is to have any student about whom you are concerned get a good general medical examination. As with adults, children's bodies respond to the stress of the death of someone loved. School nurses, pediatricians, and family physicians are among those who most commonly refer bereaved children for help.

In many situations, the physical "hurts" the child expresses are a form of emotional communication. After all, children often learn that when you do not feel well (whether emotionally, spiritually, or physically), the most immediate way to receive attention is to be "sick." Even very young children pick up on these cues. If the child is in a closed family system where open mourning is discouraged, this tendency is heightened (Shapiro, 1994). The child unconsciously reasons, "If I can't play it out, act it out, or talk it out, I'll get sick and then maybe I'll get nurtured."

Learning disabilities, injury, illness, and hospitalization are obviously loss experiences for children. To experience bereavement on top of these types of losses may create normal feelings of physical vulnerability and, in general, a lack of wellness. Children with concerns about their own physical well-being ("Will I die too?") will often express these concerns indirectly through a preoccupation with their health.

Six Reconciliation Needs of Mourning

How does a bereaved child mourn from the starting point of grief through the many thoughts and feelings to the destination of reconciliation and growth? Asked more simply, how *does* the bereaved child heal? I believe the bereaved child heals, over time, when mourning needs are consistently met (Wolfelt, 1996). For a flower to grow, the plant must receive adequate nutrients from the soil, adequate water, and sufficient sun. It also needs protection from pests, disease, and invasive weeds. The gardener who understands and helps his plants meet these needs will be rewarded with a lush, healthy garden. Bereaved children have fundamental needs that must be met if they are to heal and grow (Wolfelt, 1996). I call them "the six reconciliation needs of mourning." Others have labeled these the *tasks* of childhood mourning (Worden, 1996). As a school professional, you probably know many of the needs of a mourning child, but you may never have analyzed and articulated them in this manner. I find that doing so helps me better understand each child's grief journey and my role as their companion.

Need 1. Acknowledge the Reality of the Death.

Before children can move on in their grief journeys, they must be helped to gently confront the reality that someone they love has died and will not return. Children must be provided with an open and honest explanation (at their level of developmental understanding) about the nature and cause of the death if they are to meet this mourning need. As caring adults, it is important to openly share clear information about the death with the affected children (Wolfelt, 1996). Remember, children can cope with what they know. They cannot cope with what they do not know.

We as a society must work to overcome our instinct to protect children from sad news. We must also refrain from thinking that children are "too young to understand." Perhaps they are too young to fully understand everything about the death, but they are never too young to feel (Wolfelt, 1983, 1996).

In my experience, the news of a death is best conveyed by someone close to the child. When possible, it should come from someone who has a preexisting, stabilizing relationship with the child. Keep in mind the importance of eye contact, a comforting tone of voice, and appropriate physical comfort that conveys security. Be certain to avoid euphemisms such as "sleep" and "passed away," which will only confuse the child.

As school professionals, you are more likely to see children who have already been told about a death. So, while at times you may not be able to influence the way in which children first hear about the death of someone loved, you can help explain what death means. It is important to listen to the children share their understanding of the death (Wolfelt, 1996). If a child teaches you that he or she does not understand what death is all about, explain that the dead person's body has stopped working and it will never again work the way it used to. The person's body will not see or hear and will not talk, move, or breathe anymore. The body will not feel cold or hot or be happy or sad. When a person's body dies, the person does not feel anything anymore. These kinds of explanations help children understand that the person who died cannot come back. In my experience, being supportive of children as they gently confront this new reality is a vital part of helping with this reconciliation need of mourning.

Do not expect that a child's acknowledgment of the reality will be similar to an adult's response. Many children respond to news of death with indifference or an apparent lack of feelings. This is the child's natural way of protecting him- or herself. These children will embrace the full reality of the death only intermittently. A lack of outward mourning does not mean that children are not moving toward the reality—they are just doing it in their own way and time.

Many times a bereaved child asks questions that are prompted by this need to acknowledge the reality of the death. Do not try to attach adult meanings to children's questions, which are usually quite simple and factual. The questions they ask and re-ask are one of the central ways in which they embrace the full reality of death.

The ability to acknowledge the reality of the death often only comes about after the child is provided with opportunities to talk-out, play-out, and even act-out the circumstances of the death (Webb, 1993; Wolfelt, 1996). In my experience, it is typical that a child may not embrace the full sense of loss until several months after the death. (Meeting this need can take *years* if the child has been told half-truths or out-and-out lied to about the reality of the death.) Before that, the child will likely, consciously and unconsciously, work to distance him- or herself from the pain that is part and parcel of meeting this critical first mourning need.

For the adult caregiver, the art of helping meet this need lies in balancing the child's need to acknowledge this new reality with the child's normal desire to push the reality away. As we learn to companion children in grief—and not to push or pull them through the experience—we become capable of being true helpers. We become available to children not only with our heads, but with our hearts.

Need 2. Move Toward the Pain of the Loss While Being Nurtured

To heal, the bereaved child should be encouraged to embrace the wide range of thoughts and feelings that result from the death (Wolfelt, 1996). This task is often complicated by adults who want to protect children from the impact of the death. This tendency is understandable, but in prematurely moving them away from the hurts of grief, well-intentioned but misinformed adults can interfere with their healing and may even cause long-term harm.

The desire of many adults to "spare children" is often caused by their own feelings of discomfort, fear, or anxiety. Too often it appears that adults attempt to have children avoid feelings of pain and hurt, so that they will not have to "be with" them in the grief journey. The sad reality is that many adults are trying to protect themselves from pain by protecting children from pain.

As grief gardeners, we must be careful not to blame or shame those adults who have adopted this overprotective stance (Wolfelt, 1996). After all, they have grown up in a culture in which the role of pain is misunderstood. In our society, to feel and express thoughts and feelings (or in a child's situation, to play- or act-out these feelings) connected to loss is often considered unnecessary and inappropriate (Kastenbaum, 2000). Mourning makes many of us uncomfortable. Yet, in reality, it is in moving toward our hurts that we ultimately heal.

So, to heal from losses in our culture takes tremendous courage, particularly for children. Many children must overcome adult behaviors such as isolation, deception, and overprotection from the events surrounding death. The art of helping bereaved children with this need is to allow them to teach you how they feel. You cannot prod children into this, but you can work to create a safe, nurturing environment where they sense your desire to understand. In my experience, many bereaved children need permission to mourn. Sometimes what they need most from adults is an awareness that it is okay to talk about and play-out their many thoughts and feelings. If the suffering is avoided, denied, or repressed by adults surrounding bereaved children, those very children will be abandoned at a time when they most need the presence of loving adults. It is not really a question of, "Will the child feel or not feel?" It is a question of, "When she feels, will she be able to express herself in the companionship of caring adults?"

If we are to be those caring adults, we must also be careful not to project to bereaved children that they will (or should) feel exactly as we do about death. So, while the child must move toward whatever feelings he or she experiences, keep in mind that these feelings can be, and often are, very different from an adult's grief feelings.

We must also remember that children mourn intermittently, moving at times toward and then away from the depth of the loss (Wolfelt, 1996). Respecting children means acknowledging this wave-like quality in their capacity to mourn. This also means remaining available as a stabilizing presence long after the event of the death.

Moving toward the pain of the loss is just one facet of this reconciliation need. The child's simultaneous need to be nurtured physically, emotionally, and spiritually is the other facet. Physically, the child needs adequate nutrition and hydration, daily rest, and regular physical activity. Children's emotional needs are many but, minimally, what each child needs is a safe psychological environment and a nurturing support system that ensures they are loved and cared for.

Need 3. Convert the Relationship From One of Presence to One of Memory

This reconciliation need involves allowing and encouraging children to move from the "here and now" of their relationship with the person who died to the "what was." Although the bereaved child should not be expected to give up all ties to the person who died (actually, it is unwise and often damaging to communicate to the child that any and all relationships with the person who died are over), the relationship must be altered from one of presence to one of memory.

Precious memories, occasional dreams reflecting the significance of the relationship, and living legacies are among the manifestations of this different form of a continued relationship. The process of beginning to embrace memories often begins with the funeral. Unfortunately, some adults prevent children from this vital part of the work of mourning by excluding them from the funeral. Remembering the person who has died through the funeral helps affirm the value of the life that was lived.

In my experience, the memories that families share during this time often set the tone for the changed nature of the relationship. The ritual encourages the expression of cherished memories and allows for both tears and laughter. Memories that were made in love can be gently embraced in the companionship of loving adults. Remembering can be a very slow, painful, and incremental process. When children are particularly hurting from the sting of grief, nonjudgmental support and understanding may be what is most needed. As school professionals, however, you must sometimes encourage the gentle encountering of memories. Stimulating the child to keep memories alive rather than blocking them out helps affirm the value of the relationship. In a culture where many people do not understand the value and function of memories, most bereaved children will need help meeting this important mourning need.

Based on my experience, there are many ways you can help bereaved children with memory work. A few examples include: (a) modeling the expressions of your own feelings and memories; (b) encouraging the child to teach you about some of her own memories; (c) providing the child with keepsakes that belonged to the person who died; (d) allowing the child to be involved in the funeral ritual; (e) talking about experiences the child had with the person who died; (f) displaying photos of the person who died; (g) visiting places of special significance that stimulate memories; (h) naturally bringing up the person who died in conversations with the child; (i) reviewing photo albums together at special times like holidays, birthdays, and anniversaries; and (j) keeping in mind any major milestones that might create occasions for reminiscing (e.g., graduating from grade school to middle school, the anniversary of the death, the child's own birthday).

Perhaps one of the best ways to embrace memories is through the creation of a "Memory Book" (i.e., a scrapbook containing photos, mementos, letters, reflective writings) that commemorates the person who died. This scrapbook will often become a valued collection of memories that the child will call upon often during the grief journey.

Special mention should be made of children with ambivalent memories, particularly those children whose memories are marked by emotional, physical, or sexual abuse. These kinds of experiences make it naturally difficult to openly embrace memories. These children need nonjudgmental adults they trust enough to help them explore these painful memories (Wolfelt, 1996). These kinds of memories complicate the task of mourning and require your special professional attention. Children who are not helped to place these memories in perspective (and helped to understand that they were victims) may carry an underlying sadness or anger into their adult lives.

My experience in working with (and learning from) thousands of bereaved children is that remembering makes hope possible. Bereaved children's futures become open to new experiences and relationships to the extent that past memories have been embraced.

Need 4. Develop a New Self-Identity

Among the most difficult changes bereaved children encounter are those that impact their personal identities. Personal identity or self-perception comes from the ongoing process of establishing a sense of who one is. The death of someone loved can, and often does, permanently change the child's self-perception.

To experience the death of a parent, grandparent, brother, sister or best friend is among life's most stressful encounters for children. The specific role in the child's life played by the person who died is critical to the child's self-definition. As 10-year-old Katie said after the death of her mother, "I used to have a mommy who loved me and took care of me. Now, I don't have a mommy here for me anymore." Obviously, Katie was confronted with the difficult task of redefining herself without the presence of her loving mother.

As children work on this central need of mourning, every aspect of their capacity to cope is tested. The bereaved child often finds him- or herself thinking, feeling, and acting in ways that seem totally foreign. This process appears to be an inherent part of the search for a new identity in the absence of the person who died.

Social and functional role changes must be integrated into the bereaved child's new identity. For example, having a mother or father is typically a vital part of a child's self-concept. To go from having a mother or father to not having one is a process, not an event. Beyond the change in self-identity, there is also the loss of the "old" part of one's self—the significant part attached to one's parent. The child is mourning the loss not only on the outside, but also on the inside.

Well-intentioned, yet misinformed, adults sometimes reinforce a new "hypermature" identity on the part of the bereaved child. This happens in response to comments such as this: "Now you have to be the man of the house." While everyone in the family will have new roles and responsibilities when a death occurs, we should never assign inappropriate role responsibilities to children. To encourage a boy or girl to be the "man" or "woman" of the house can damage his or her capacity to mourn and heal.

The trauma of grief for bereaved children can also result in what I would term a "regressive self-identity." Early on in grief there are often some regressive expressions of self-identity. You might observe the child teaching you that he or she has a temporary heightened dependence on others, feelings of helplessness, frustration, inadequacy, and fearfulness, as well as a generalized feeling of loss of control over the environment. These feelings usually hearken back to earlier developmental periods in which these self-images were a part of the child's learning experiences. These feelings can be frightening to the child, but they are actually a natural response to this reconciliation need of mourning.

During the early days of their grief journey, bereaved children typically call on any and all of their resources just to survive. Their "regressive" thoughts, feelings, and behaviors are a natural and appropriate means of trying to survive the trauma to their self-identity. As they begin to heal in grief, their need to regress typically lessens. If these regressive self-reflections do not change over time, the child is simply attempting to teach you about his or her need for support and understanding.

The identity of bereaved children is also impacted in that they become aware that they and others around them are mortal. They learn that they are not immune from the potential of experiencing losses in life. Some of these children develop a more serious or cautious view of themselves that reflects this sense of vulnerability. As caring adults, we must be watchful that this potential seriousness does not hinder the child's long-term capacity to play and have fun. Sometimes, bereaved children who have not been helped to work through such feelings grow to become chronically depressed adults (Cerel et al., 1999). This is a reminder that working with bereaved children is an excellent way of practicing preventive, proactive mental health care.

On the brighter side, I have also seen many bereaved children evolve more compassionate self-identities. They often develop a special sensitivity to the needs of others, demonstrate patience, and have a gift for being nurturing. Essentially, their experience of personal suffering can enhance their ability to be sensitive, compassionate, and aware of the needs of others who have losses in life. A way I like to say it is that the bereaved child's gift in helping others often comes from embracing and learning from the pain of his or her own loss.

Each year thousands of bereaved children begin their encounter with this reconciliation need of mourning. Unfortunately, many of them will struggle with their changed identities alone and in isolation. School professionals have a responsibility to companion bereaved children as they struggle with many of these self-identity issues.

Your desire to understand, coupled with consistency, trust, and security in the child's environment during this time, are critically important.

Need 5. Search for Meaning in the Loss

This reconciliation need involves allowing the child to search for and restore a sense of meaning in life after the death. After the death of someone loved, the child's perception of the meaning and purpose of life is naturally changed. Many adults are surprised to learn that even young children search for meaning when they are bereaved.

In the process of working on this need of mourning, meaning is usually searched for through "How?" and "Why?" questions. The bereaved child will only verbalize these questions to adults whom they trust. When these conditions are met, the child will teach you about his or her search for meaning not only in words, but more frequently through play and acting-out behaviors.

A few examples of questions the child might naturally be exploring are: How could a drunk driver crash and kill my mommy? Why didn't my daddy's body work right? How can my sister die when she is younger than me? It is interesting to note that many adults make the mistake of thinking they must always have answers to the bereaved child' questions. An essential component of truly helping bereaved children is to know we do not have all the answers. In acknowledging our "not knowing," we ultimately become more helpful to the child who is searching for meaning. This may seem paradoxical, yet it appears to hold true in my work with thousands of bereaved children.

Suffering is inherent to the child's work on this reconciliation need. As caring adults, we naturally feel uncomfortable when we see a child who is hurting physically, emotionally, or spiritually. Yet, suffering is a painful yet natural part of the work of mourning. So, perhaps it will be helpful to explore the role of suffering in the context of this central reconciliation need of childhood mourning. I do not mean to suggest that suffering is a naturally desirable event. However, suffering is as much a part of life as is happiness, and the way that we respond (regardless of age) to unavoidable suffering will in many ways determine the meaning we give to life. Actually, we all in part heal through embracing hurt.

Our Western culture does not appear to understand the role of hurt, pain, and suffering in the healing process. We have to remind ourselves of the collective wisdom of the ages that says people reflect on the true meaning of life when they experience loss. Through the search for meaning, many bereaved children have taught me that they have grown in ways that, without knowing the pain of human loss, they otherwise might not have grown.

I would be remiss here if I did not note that the many children subject to great hunger, poverty, and deprivation are not experiencing growth through such suffering. As a matter of fact, premature death is usually the consequence of this kind of suffering. This teaches us that basic security needs must be fulfilled before a bereaved child can do work related to the search for meaning.

However, when these basic security needs are met, hundreds of bereaved children have helped me understand that they can and do respond to the death with an amazing capacity to search for and find continued meaning in their lives: Six-year-old Charles taught me, "Ghosts have learned goodness from the people in my life who have died." Eight-year-old Diane taught me, "The people in Heaven have my grandma to watch over them now." Ten-year-old James taught me, "When I feel sad I think of all the fun times we had." Sixteen-year-old Shawn taught me "Since my mom's death I'm very aware of other teenagers who I can help with their losses." These are but a few examples of how children can and will teach you that, if you allow them to ask how and why questions, they will search for—and find—continued meaning in life. If you disallow their mourning in general or project that you have all the answers, odds are that you will complicate this important task of mourning.

With support and understanding, bereaved children usually learn early in life that human beings cannot have complete control over themselves and their world. They learn that faith and hope are central to finding meaning in whatever one does in this short life. They learn a true appreciation for life and what it has to offer. They learn that it is the little things that sometimes matter the most. They learn a growing sense of gratefulness for all that life has to offer. They learn to look for the goodness in others. They learn an empathetic appreciation for the suffering of others. Perhaps most of all, they learn not only how to meet their own needs, but also how to help others meet theirs.

Need 6. Experience Long-Term Support

We have come to understand that grief is a process, not an event (Wolfelt, 1996). The long-term nature of grief means that bereaved children will need adult "stabilizers" in their lives long after the event of the death. Unfortunately, because our society places so much value on the ability to "carry on," "keep your chin up," and "keep busy," many bereaved children are abandoned shortly after the event of the death.

In spite of our awareness that children mourn long after the death occurs, attitudes are slow to change. "It will be best not to talk about it," "It's over and done with," and "It's time to get on with life" still dominate the messages that many bereaved children receive. These kinds of messages inhibit grief rather than allow for its expression. Individuals who see children's grief as something that must be overcome or simply endured typically do not remain available to the child very long after the event of the death. In my experience, these adults encourage children to go around their grief, instead of toward or through it.

Even those children who actively participate in the work of mourning will need stabilizing adults in their lives long after the event of the death. As children grow into adulthood, they will mourn the loss in different ways at various developmental phases (Baker & Sedney, 1996; Corr, 2000). (See Chapter 16, Developmental Aspects of Psychological Trauma and Grief, in this volume for further discussion.) To be truly helpful, adult caregivers must appreciate the impact of loss on children. They must understand that, to heal, the child must be allowed and encouraged to mourn long after the event of the death. They must view grief not as an enemy to be overcome, but as a necessary consequence of having loved.

Stabilizing adults must also be aware that a child's "griefbursts"—heightened periods of loss and sadness—demand understanding, not judgment. Griefbursts often occur during pivotal life moments: birthdays (the child's own or the person's who died); starting or getting out of school for the year; a change of seasons; receiving a report card; holidays; vacations; weekends; the child's first date; graduating from school; achieving a major goal; getting married; the birth of children; or any kind of anniversary. In my experience, it appears that these unsuspecting waves may come out of nowhere, stimulated through a sight, a sound, or a smell. Unless the child (or adult who is reflecting on childhood loss) shares this experience with someone, he or she often suffers in silence. As caring adults, we must stay alert for these griefbursts.

The "bereaved" label is an attempt on the part of society to identify a group of people with special needs. The bereaved child does have special needs. One of the most important is the need to be companioned long after the event of the death. School professionals have a responsibility to remain available to these children long into the future.

I hope this outline of reconciliation needs assists in companioning bereaved children. The responsibilities of adult caregivers are complex and ever-changing as the bereaved child participates in the work of mourning. Helping the child meet these reconciliation needs demands emotional and personal as well as intellectual and professional involvement.

Each of the six reconciliation needs I have outlined is accompanied by its own challenges and stresses to both the mourner and the helper. To be of true help, you must: (a) have a desire to have the child be your teacher; (b) understand how your own experiences with loss influence your capacity to be emotionally, physically, and spiritually available to the child; (c) allow yourself to empathetically enter into the pain of the child; (d) work to understand the challenges being presented to the child in the work of mourning; and (e) develop a wide range of helpful skills that assist the child in reconciling the loss. I hope that, like me, you are excited by the prospect of such challenging, rewarding, valuable work.

Nine Common Myths of Childhood Grief

Myth 1: Grief and Mourning are the Same Experience

People tend to use the words "grief" and "mourning" interchangeably. There is, however, an important distinction between the two—a distinction that becomes all the more critical for those who work with bereaved children. *Grief* represents the thoughts and feelings that are experienced within children when someone they love dies. Grief is the internal meaning given to the experience of bereavement. *Mourning*, on the other hand, means taking the internal experience of grief and expressing it outside oneself. Another way to think of mourning is "grief gone public," or "sharing one's grief with others." Because bereaved children mourn more through their behaviors than they do through words, mourning for them is typically not expressed in the same ways it is for adults.

We often refer to children as "forgotten mourners." Though children grieve, we as a society often do not encourage them to mourn. As professional helpers, on the other hand, we have the responsibility and the privilege to create conditions in which children can mourn.

Myth 2: Children Only Grieve for a Short Time

Bereaved children do not heal quickly (Webb, 1993; Wolfelt, 1996; Worden, 1996). Still, many adults do not understand that grief and mourning are processes, not events. Those adults who want the bereaved child to "hurry up" and "get over it" usually project that the child needs to be strong and stoic.

I continue to read in professional texts comments such as, "If the child's symptoms persist past six months, they should be referred for professional assistance." Actually, nothing could be further from the truth. Around six months after a death, it is not unusual to see *more*, not fewer, visible signs of mourning in a child. This is largely because, for children, grief gets intertwined with the developmental process. If I'm just five years old when I first come to grief, that grief will change for me as I mature and begin to understand it with more cognitive depth.

So how long should a child's grief last? In my experience, if ideal conditions exist (which they rarely do), active mourning can take years for children actively working on their six needs of mourning with the support of caring adults and family members. Even those fortunate children will encounter intermittent mourning as they develop and reintegrate their grief experience. My best advice is this: If you are seeing mourning behaviors in a bereaved child, the child still needs your support.

Myth 3: A Child's Grief Proceeds in Predictable, Orderly Stages

Have you ever heard a well-meaning but misinformed someone say of a bereaved child, "He's in stage two"? If only it were that simple! People use the "stages of grief" to try to make sense of an experience that is not as orderly and predictable as we would like it to be. The concept of "stages" was popularized with the publication of Elizabeth Kubler-Ross' (1969) landmark text *On Death and Dying*. Kubler-Ross never intended that people should interpret her "five stages of dying" literally. However, many people have done just that, not only with the process of dying, but with the processes of bereavement, grief, and mourning as well.

No two children are alike. No two children will grieve in the same way. As caring adults, we only get ourselves in trouble when we try to prescribe what a child's grief and mourning experiences should be. You must encourage bereaved children to teach you about their needs: "Teach me about your grief, and I will be with you. As you teach me, I will follow the lead you provide and attempt to be a stabilizing and empathetic presence."

To think that one's goal is to move children through the stages of grief would be a misuse of counsel. Children experience a variety of unique thoughts, feelings, and behaviors as part of the healing process. We must remind ourselves not to prescribe how and when they should mourn, but allow them to teach us where they are in the process.

Myth 4: Caregivers Do Not Have to Mourn for Their Children to Mourn

My experience has taught me that parents and other significant adults in a child's life have the biggest influence on the child's own grief experiences. The problem comes when parents, however loving and well-intentioned, try to conceal their own grief and mourning from their children in an attempt to protect them from more pain. This is a mistake. Modeling is a primary way in which children learn. Children instinctively love and try to emulate their parents. So when the parents deny their own grief, they teach their children to do the very same thing (Rosen, 1996). When Mom or Dad is openly sad, children learn that mourning is okay and that the sadness everyone is feeling is not their fault. Children who have not been taught these things will often assume they are responsible for the emotional environment of the household. One of the most loving things we can do as bereaved adults is allow ourselves to mourn; the first step in helping bereaved children is to help ourselves. In fact, our ongoing ability to give and receive love *depends* on our willingness to mourn in healthy ways.

Myth 5: Bereaved Children Grow to be Maladjusted Adults

Bereaved children can heal and grow with early intervention and compassionate care. Historical research may have us believe otherwise. Since the 1930s, numerous studies have attempted to establish relationships between childhood bereavement and later adult "mental illness" (depression, psychosis, sociopathic behavior; Cerel et al., 1999;

Finkelstein, 1988). More recently, however, analyses of the literature have questioned these results because of methodological problems with the studies (Worden, 1996).

Still, people perpetuate this myth. You may have witnessed this when adults approach bereaved children with this patronizing attitude: "You poor child. You will be forever maimed by this experience." However, bereaved children are not damaged goods. In my own experience, if adults create conditions that allow a child to mourn in healthy ways, there is no reason for the self-fulfilling prophecy that the child will be irreparably harmed by the death. I do agree that bereaved children are at *risk* for emotional problems, but only if they are not compassionately companioned in their grief journeys. If we create conditions that help children mourn, they'll go on to live and love well.

Myth 6: Children Are Better Off if They Do Not Attend Funerals

Adults who have internalized this myth create an environment that prematurely moves children away from grief and mourning. The funeral provides a structure that allows and encourages both adults and children to comfort each other, openly mourn, and honor the life of the person who has died (Wolfelt, 1996). Meaningful funerals form the foundation for healthy mourning. If we skip these crucial first steps, we fail to prepare adequately for the future.

Children, who after all are mourners too, should have the same opportunity to attend funerals as any other member of the family or community. They should be encouraged to attend, but never forced. I emphasize the word "encouraged" because some children are anxious when experiencing something unknown to them. Through gentle encouragement, loving adults can help bereaved children know they will be supported during this naturally sad and frightening time in their young lives. The funeral can even provide an opportunity for children to express their unique relationship with the person who has died by including a ritual of their own during the service.

Myth 7: Children Who Cry Too Much Are Being Weak and Harming Themselves

Crying is the body's natural response to sadness. It helps children release internal tensions and allows them to communicate a need to be comforted. Children may repress their tears (and other emotional releases) either because they have internalized adult demands for repressing feelings, or they have observed that the adults around them repress their own tears. Unfortunately, many adults associate tears of grief with personal inadequacy and weakness. When bereaved children cry, adults often feel helpless. Out of a wish to protect the children (and themselves) from pain, well-meaning, misinformed adults often discourage crying through comments such as, "You need to be strong for your mother," or "Tears won't bring him back," and "He wouldn't want you to cry."

Another purpose of crying is postulated in the context of attachment theory, wherein tears are intended to bring about reunion with the person who has died (Bowlby, 1960, 1980, 1982). When a bereaved six-year-old cries, the child may be thinking (consciously or unconsciously) that the dead mother will return to comfort him or her. After all, they always were hugged and kissed by her when they cried before. The frequency and intensity of crying eventually wanes as the hoped-for reunion does not materialize.

Tears are not a sign of weakness in children *or* adults. In fact, when bereaved children share tears they are indicating their willingness to do the work of mourning. As loving adults, we can better assist children by crying ourselves when we feel the need.

Myth 8: Children Are Too Young to Understand Death

Perhaps you have heard an adult say, "I'll just tell them he's gone to heaven and that will take care of it." If only it were that simple! As one eight-year-old girl asked me, "If Grandpa is in heaven, why did we put him in the ground?" Teaching abstract concepts about death and religion is no easy task, but it is one we must take seriously as we try to help bereaved children.

Bereaved children need age-appropriate care. It is true that children are too young to *completely* understand death and the religious and spiritual belief systems surrounding death. Only over time will children assimilate these beliefs, and this developmental limitation must be respected. But no matter the specific beliefs of the family, the child must first be helped to understand that the person has died and cannot come back. It is a mistake to suggest that children need not mourn because the person who died "is in a better place anyway." To discourage children from mourning in this way is to set them up for a multitude of complications.

Many children naturally become frightened when they hear that after death people go to some poorly defined place (such as "the sky") for some poorly defined reason. For example, several times after a child has died I have learned that the surviving children—siblings and friends—had been told by their parents or church pastor that God needed a little boy or girl in heaven, so the child was "taken." I have counseled several children who were counting the days until they too would be "taken." Not surprisingly, these children were having trouble sleeping and were experiencing generalized feelings of anxiety. This kind of misguided communication can have long-term damaging effects on the child's emotional well-being.

In sum, caring adults need not feel guilty or ashamed if they cannot give specific definitions of God and heaven, or what happens after death. Openness to mystery is valuable not only in teaching about death, but also in teaching anything about life. On the other hand, we should not proffer pseudo-explanations that may frighten or confuse children.

Myth 9: We Should Help Children "Get Over" Their Grief

Healthy mourning necessarily takes a long time—months, years, and even lifetimes (Worden, 1996). In fact, children never overcome grief; they live with it and work to reconcile themselves to it. As bereaved children go about the work of mourning, they begin to realize that life will be different without the person who died. Hope for a continued life emerges as children are able to make commitments to the future. Children eventually realize that the dead person will never be forgotten, yet they know that their own lives can and will move forward. Children do not get over grief; they learn to live with it. Those who think the goal is to "resolve" bereaved children's grief become destructive to the healing process.

The Reconciliation of a Child's Grief

In many grief models, the final "stage" of bereavement is referred to as resolution (Wolfelt, 1996; Worden, 1996). Other paradigms use the terms recovery, reestablishment, or reorganization. The problem with these definitions is that people—children and adults alike—do not "get over" grief. My personal and professional experience tells me that a total return to "normalcy" after the death of someone loved is not possible; everyone is forever changed by the experience of grief. Recovery, as it is often understood by mourners and caregivers, is erroneously seen as an absolute, a perfect state of reestablishment.

Reconciliation is a term I find more appropriate for what occurs as the bereaved person works to integrate the new reality of moving forward in life without the physical presence of the person who has died. With reconciliation comes a renewed sense of energy and confidence, an ability to fully acknowledge the reality of the death, and a capacity to become reinvolved in the activities of living. There is also an acknowledgment that pain and grief are difficult, yet necessary parts of life.

The bereaved child's reconciliation after a death *is a process, not an event* (Wolfelt, 1996). Adults should avoid using specific timetables with specific points at which a child should "be over" grief. Human beings never get over grief, but instead become reconciled to it. Caregivers who allow and encourage children to move toward their grief, instead of away from it, aid in this reconciliation process.

Among the changes often noted during the child's reconciliation process are: (a) a return to stable eating and sleeping patterns, (b) a renewed sense of energy and well-being, (c) a subjective sense of release from the person who has died, (d) increased thinking and judgment-making capabilities, (e) the capacity to enjoy life experiences, (f) a recognition of the reality and finality of the death, and (g) the establishment of new and healthy relationships. Perhaps the most important gain for the child in this reconciliation process is the discovery of the ability to cope successfully with the loss. This coping is achieved only with the assistance of caring adults.

In Summary

Because many students will experience the loss of a close or special person and grief will naturally occur following these early losses, educators have the responsibility to be prepared to provide support to these bereaved children. As outlined above, it is important to address the mourning needs of grieving children, whether they are affected by the death of a family member, neighbor, friend, teacher, or schoolmate. In understanding *the six reconciliation needs of mourning*, as presented above, compassionate educators may provide important assistance in facilitating healthy mourning. It is especially important to be sensitive to the perceptions and circumstances of bereaved children, listen to them, and allow them to teach you about their needs.

References

Baker, J., & Sedney, M. (1996). How bereaved children cope with loss: An overview. In C. A. Corr & D. M. Corr (Eds.), *Handbook of childhood death and bereavement* (pp. 109-130). New York: Springer.

Bowlby, J. (1960). Grief and mourning in infancy and early childhood. *Psychoanalytic Study of Children, 15*, 9-52.

Bowlby, J. (1980). *Attachment and loss: Loss, sadness, and depression*. New York: Basic Books.

Bowlby, J. (1982). *Attachment and loss: Attachment*. New York: Basic Books.

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Shweers, J., & Canobbio, R. (1994). Major depression or uncomplicated bereavement? A follow-up of youth exposed to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 33*, 231-239.

Cerel, J., Fristad, M. A., Weller, E. B., & Weller, R. A. (1999). Suicide-bereaved children and adolescents: A controlled longitudinal examination. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 672-680.

Corr, C. (2000). What do we know about grieving children and adolescents? In K. Doka (Ed.), *Living with grief: Children, adolescents, and loss* (pp. 21-32). Philadelphia: Brunner/Mazel.

Crenshaw, D. A. (1990). *Bereavement: Counseling the grieving throughout the life cycle*. New York: Crossroad.

Doka, K. J. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, MA: Lexington Books.

Finkelstein, H. (1988). The long-term effects of early parent death: A review. *Journal of Clinical Psychology, 44*, 3-9.

Kastenbaum, R. (2000). The kingdom where nobody dies. In K. J. Doka (Ed.), *Living with grief: Children, adolescents, and loss* (pp. 5-20). Philadelphia: Brunner/Mazel.

Kubler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Lehmann, L., Jimerson, S., & Gaasch, A. (2001). *Grief support group facilitators handbook*. Philadelphia: Brunner & Routledge.

McCann, I., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.

Rando, T. (1993). *Treatment of complicated mourning*. Champaign, IL: Research Press.

Rosen, E. J. (1996). The family as a healing resource. In C. A. Corr & D. M. Corr (Eds.), *Handbook of childhood death and bereavement* (pp. 223-244). New York: Springer.

Shapiro, E. R. (1994). *Grief as a family process: A developmental approach to clinical practice*. New York: Guilford Press.

Silverman, P. R., & Worden, J. W. (1992). Children's reactions to the death of a parent in the early months after the death. *American Journal of Orthopsychiatry, 62*, 93-104.

Stillion, J. M. (1996). Survivors of suicide. In K. J. Doka (Ed.), *Living with grief: After sudden loss* (pp. 41-52). Washington DC: Hospice Foundation of America.

van der Kolk B., & Saporta, J. (1991). The biological response to psychic trauma: Mechanisms and treatment of intrusion and numbing. *Anxiety Research, 4*, 199-212.

Webb, N. B. (1993). *Helping bereaved children: A handbook for practitioners*. New York: Guilford Press.

Wolfelt, A. (1983). *Helping children cope with grief*. Bristol, PA: Accelerated Development.

Wolfelt, A. (1996). *Healing the bereaved child: Grief gardening, growth through grief and other touchstones for caregivers*. Ft. Collins, CO: Companion.

Worden, J. W. (1996). *Children and grief: When a parent dies*. New York: Guilford Press.

Appendix

The Grieving Child's Bill of Rights

Someone you love has died. You are probably having many hurtful and scary thoughts and feelings right now. Together those thoughts and feelings are called grief, which is a normal (though really difficult) thing everyone goes through after someone they love has died.

The following 10 rights will help you understand your grief and eventually feel better about life again. Use the ideas that make sense to you. Post this list on your refrigerator or on your bedroom door or wall. Re-reading it often will help you stay on track as you move toward healing from your loss. You might also ask the grown-ups in your life to read this list so they will remember to help you in the best way they can.

1. ***I have the right to have my own unique feelings about the death.*** I may feel mad, sad, or lonely. I may feel scared or relieved. I may feel numb or sometimes not anything at all. No one will feel exactly like I do.

2. ***I have the right to talk about my grief whenever I feel like talking.*** When I need to talk, I will find someone who will listen to me and love me. When I don't want to talk about it, that's OK, too.

3. ***I have the right to show my feelings of grief in my own way.*** When they are hurting, some kids like to play so they'll feel better for awhile. I can play or laugh, too. I might also get mad and scream. This does not mean I am bad, it just means I have scary feelings that I need help with.

4. ***I have the right to need other people to help me with my grief, especially grown-ups who care about me.*** Mostly I need them to pay attention to what I am feeling and saying and to love me no matter what.

5. ***I have the right to get upset about normal, everyday problems.*** I might feel grumpy and have trouble getting along with others sometimes.

6. ***I have the right to have "griefbursts."*** Griefbursts are sudden, unexpected feelings of sadness that just hit me sometimes—even long after the death. These feelings can be very strong and even scary. When this happens, I might feel afraid to be alone.

7. ***I have the right to use my beliefs about my god to help me deal with my feelings of grief.*** Praying might make me feel better and somehow closer to the person who died.

8. ***I have the right to try to figure out why the person I loved died.*** But it's OK if I don't find an answer. Why questions about life and death are the hardest questions in the world.

9. ***I have the right to think and talk about my memories of the person who died.*** Sometimes those memories will be happy and sometimes they might be sad. Either way, these memories help me keep alive my love for the person who died.

10. ***I have the right to move toward and feel my grief and, over time, to heal.*** I'll go on to live a happy life, but the life and death of the person who died will always be a part of me. I'll always miss him or her.

Note

Adapted and reprinted with permission. Wolfelt, A. (1996). The Grieving Child's Bill of Rights. Ft. Collins, CO: Companion. Available Online: *www.centerforloss.com*

669

33

危機

Innovative Treatment Methods for Psychological Trauma

Kathleen Nader, D.S.W.
Two Suns (Cedar Park, TX)

Multiple issues and their interactions affect a child's symptomatic presentation and needs in treatment initially and over time (Nader, 2001, in press). Clinicians must consider such characteristics as the nature of the traumatic event (Nader, 1997a, 1997b, Nader, 2001; Terr, 1991), developmental issues (Combrinck-Graham, 1991; Nader, 2001; Rossman, Bingham, & Emde, 1997; Scheeringa & Zeanah, 1995), cultural issues (Heras, 1992; Nader, Dubrow, & Stamm, 1999), attachment styles (Ainsworth, 1973; Bowlby, 1969, 1973; James, 1994; Thompson, 1991), temperament and personality (Delunas, 1992; Nader, 2001), and memory (Howe, 1997; Lewis, 1995; Nader, 2001; Pynoos & Nader, 1989; Terr, 1994).

In the past two decades, we have developed and adapted a number of methods to address children's traumatic reactions (Nader, 2001). Used effectively, the innovative treatment methods described in this chapter can reduce symptoms of posttraumatic stress disorder (PTSD), reduce or prevent the escalation of other associated symptoms (e.g., depression), and assist recovery of the child's confidence, competence, and sense of control.

It is essential to recognize that we have not yet learned to measure some of the specific outcomes of trauma that occur in addition to PTSD and we have not measured PTSD and associated symptoms over several years or into adulthood. Furthermore, many studies have not included the most severely traumatized individuals (Friedrich, 1996). This chapter discusses some of the issues relevant to choosing and assessing methods of treatment and describes play therapy methods, cognitive behavioral methods, multimodal treatment methods, and methods addressing specific symptoms. It provides at least one example of each method and gives references for additional applications or adaptations of the method for traumatized youths. To be used successfully and without harm, all of the methods require a period of training and supervision.

General Treatment Issues

Some relief is afforded traumatized youths by a caring adult providing preliminary interventions or comforting contact (Nader, 1997a) or by routine community service (Friedrich, 1996). Specialized treatment methods can provide additional relief, recovery, and prevention of future disturbances in character, personality, and behavior. It is important that the treatment method focuses on the child's specific range of symptoms (Friedrich, 1996). Most, but not all, treatments described in this chapter include repeated reviews of the event and reprocessing of memories. Although the methods are described primarily for their use with youths exposed to either single incidents of trauma, multiple traumas, or ongoing traumas, some of the methods have been adapted by method co-authors for use with other populations. The amount of discussion versus play and the amount of comfort given differ across age groups (Nader, 2001, in press). Methods described in this chapter are not appropriate for youths who are cognitively challenged.

For some populations, the primary goals of treatment are those other than, or in addition to, reduction of PTSD (Nader, 2001). For example, the primary goals for youths with dissociative disorders may be reintegrating separate personalities and assisting the child to take responsibility for all of his or her own emotional states and actions. The priorities for youths exposed to ongoing violence (e.g., inner cities, war zones) may be issues such as moral code and despair. Although treating a selected range of symptoms may affect some of the other symptoms (March, Amaya-Jackson, Foa, & Treadwell, 1999), multiple treatment foci are needed for a child who presents with a range of symptoms (Friedrich, 1996; Nader, 2001, in press).

Method

Treatment is best when there is a good match among method, clinician, and child. Some methods require more communication, empathy, and/or interpretive skills than do others. All methods require an understanding of childhood trauma and specific psychotherapy principles, flexibility, rapport with children, insight, and observational skills. We have not yet clearly identified the clinician characteristics that render a clinician most suitable for practicing a particular method. Appropriately, methods are tested by those who are well trained or by a co-developer of the method or its adaptation for traumatized youths. Clinician comparisons have not been completed.

How child characteristics interact with trauma, method, and response also has not been clearly delineated. Although we have learned to make adjustments for single-incident traumas versus multiple or ongoing traumas (Cohen, 1999; Nader, 2001, in press; Parson, 1996a, 1996b), we have not studied whether specific methods are best applied for individual child characteristics (e.g., personality, temperament, locus of control) and situations (e.g., specific kinds of exposure, particular levels of trauma, kinds of previous experiences, or relationship with parents).

Location

Several studies indicate that, when a catastrophe has affected a group of youths, providing treatment on the school grounds may be the best method of ensuring intervention (Auerbach & Spirito, 1986; Nader, 1997b; Nader & Pynoos, 1993; Pynoos & Nader, 1988b; Shaw, 1997; Williams, 1994). Treatment on the school grounds eliminates transportation and procrastination problems. In addition, it provides additional sources of information regarding the child's responses and permits work with school issues, teachers, and peers when indicated.

Duration

Length of treatment will vary depending on the degree of symptom severity, family functioning, the child's readiness to change, and other factors that affect the child's life and functioning (Nader, 2001). Although studies covering a period of 1 to 2 years following treatment have demonstrated successes from the use of 2 to 48 sessions (Nader, 2001), limited information is available on the number of therapy sessions provided and treatment outcome (Friedrich, 1996). There is some evidence that length of treatment correlates positively with treatment outcome and that prior therapy experience is associated with positive outcome (Clement, 1996; Friedrich, 1996; Friedrich, Luecke, Beilke, & Place, 1992). Phase of treatment and increases in maturity, experience, and number of sessions may result in increased reports of symptoms over time or at varying periods in treatment (Friedrich, 1996; Nader, 1997a, 1997b). For example, as youths mature and learn more about themselves in treatment, they may report more symptoms.

Modality

Treatment for childhood trauma almost always includes more than one modality (e.g., individual child, parent, peer group, family group). Successes have been demonstrated by a number of individual treatment methods (Nader, 2001; Terr, 1989; Webb, 1991). Specific adjunct interventions may assist with particular results of trauma (e.g., classroom reintegration for injured youths, peer groups for grieving youths; Nader & Mello, 2000) or may address symptoms that hinder progress or functioning (e.g., arousal symptoms such as sleep disturbance, irritability, or reduced impulse control; Field, Seligman, Scafidi, & Schanberg, 1996; Glodich, 1999). Ample evidence suggests that including parents in the treatment process is preferable (Deblinger, Lippmann, & Steer, 1996; Friedrich, 1996; Nader & Pynoos, 1993; Pynoos & Nader, 1988b).

Group methods (e.g., for parents, teachers, injured, grieving, support) often have been used as important adjunctive treatments for traumatized youths (Cohen, Deblinger, & Mannarino, 1997; Nader & Mello, 2000; Silberg & Waters, 1998). A few group methods provide primary treatment for trauma symptoms (March et al., 1999; Yule & Williams, 1990). Studies comparing the use of group and individual treatment for trauma are rare (Friedrich, 1996). One study suggests a larger effect for individual than for group treatment across a range of treatment models (Chard, 1994). No outcome studies have measured results of treatments over many years.

Group methods have also been found to reduce PTSD and specific symptoms (Glodich, 1999; March et al., 1999). Group treatment offers many advantages. For example, youths learn that others in their situation have experienced similar emotions, they may accept from peers what they will not accept from adults, and the group members benefit from the work of others. Groups also can help to overcome any "conspiracy of silence" and they offer opportunities for listening without participating (Glodich & Allen, 1998; Terr, 1989).

Using groups as adjunctive treatments to individual therapy may be necessary because of the following limitations of group methods (Terr, 1989): (a) new symptoms may develop after hearing new types of horrors from others; (b) courtroom credibility is lost because of group influence; and (c) the examination of internal mental processes stimulated by trauma, which is essential to recovery, may not be possible or advisable without the privacy of individual sessions. Youths' inclinations to be greatly influenced by the expectations of their peers can be both an advantage and disadvantage of group treatment. Because youths can be strongly influenced by the perceived expectations of others, and because some aspects of traumatic experience and response are very personal, some issues that can be thoroughly addressed in the privacy of an individual session may not be addressed in a group (Nader, 2001; Terr, 1989). If, as suggested, specific traumatic impressions translate (initially or over time) into patterns of thought and behavior (Nader, 2001), then some amount of individual treatment that resolves significant traumatic impressions may be essential. Methods that include multiple modalities may be best for traumatized youths.

Play Therapy

Traumatized youths engage in play at older ages than nontraumatized youths (Nader, 2001, in press; Terr, 1989). Play therapies help to reduce clinical symptoms and to remove impediments to continuing development (Webb, 1991); they have been adapted for use with single-incident and repeated traumas (Gil, 1991, 1998a, 1998b; Webb, 1999). Methods of play therapy can differ in (a) the emphasis on play versus verbalization; (b) the amounts of direction, interpretation, and participation by the therapist; and (c) the levels and nature of guidelines and structure. Approach, sequencing, and the amount of reconstruction of the event or its episodes vary across methods, by clinician, and by age group.

Play therapy is often a component of other treatment methods (March et al., 1999; Nader, 2001). When play therapy is a component of other treatments, techniques may include drawings, stories, board games, or specific rule-guided interactions. When play therapy is the primary mode of treatment, the therapy room usually includes a variety of toys and materials that permit the child's choice of imaginative play and permit reconstruction of the traumatic experience (Webb, 1991). Drawing materials are often made available for depicting stories or events.[1]

Several styles of play therapy have been adapted for traumatized youths (Gil, 1991), including psychoanalytic (Esman, 1983; Freud, 1965; Klein, 1955), facilitated (Levy, 1938, 1939; Nader, 2001, in press; Pynoos & Eth, 1986; Terr, 1999, in press), group (Homeyer, 1999; Leben, 1995), and relationship-oriented play therapies (Axline, 1969; James, 1994) and Sand Tray Therapy.[2]

Directive Play Therapies

Effective directive play therapy expedites the abreactive reprocessing of traumatic impressions and emotions (Nader, in press). Like nondirective play therapy, directive play therapy may permit the child to direct the action or assign characters. The direction given by the clinician may be as simple as a request to focus more intensely and/or in more detail on one scene or to tell or retell a specific episode (or all) of the traumatic experience using replicas to demonstrate. The clinician's directions may also be more complex. For example, the therapist may establish a rhythm with the child in which he or she (recognizing clues from the child's symbolic drawings or actions) follows in the direction the child is moving and then adds, magnifies, assists, or even carefully pushes the child through processing a set of memories and emotions (Nader, in press). Successful directive treatment requires knowledge, training, practice, and skill in order to avoid making symptoms worse (Nader, in press). The clinician must develop the ability to anticipate the child's needs, strengths, stamina, and timing.

Trauma/grief-focused therapy. This form of therapy (Goenjian et al., 1997; Nader, 1994, 1997b, 2001, in press; Nader & Mello, 2000; Nader & Pynoos, 1991; Pynoos, 1993; Pynoos & Eth, 1986; Pynoos & Nader, 1993) is an eclectic method (Lehmann & Coady, in press) in that it combines play with other methods (e.g., abreactive, cognitive behavioral, group), treats the child in context, emphasizes a strong therapeutic relationship, recognizes the child's successes, and reduces helplessness. Within a framework of play therapy, this method includes the (a) review and re-review of aspects of the experience, (b) directed and spontaneous reenactments of traumatic episodes, (c) bringing of subconscious traumatic impressions into clear consciousness and permitting the assignment of new meaning, and (d) emphasis on intense traumatic moments before redefinition.

This method incorporates the use of play and drawings for children, with an increase in discussion and role-play or demonstration for adolescents. Toys or miniature replicas of the trauma site are provided so that youths can recreate and demonstrate the experience. The youth reviews, on multiple occasions, the traumatic experience or its episodes, essentially rewinding the mental recording as needed within a single session to review and recapture details of the experience. The clinician accompanies this review by recognizing, verbalizing, and underscoring the child's traumatic impressions (e.g., episodic or sensory impressions), emotions, desires for action or inaction (i.e., to intervene, flee, rescue, or be rescued, prevent harm, self-protect, ward off, calm, etc.), and his or her successful actions and inactions. This treatment method honors the intensity of traumatic impressions, identifications, emotions, and fantasies and facilitates their resolution (Nader, 1997b, 2001, in press; Nader & Mello, 2000; Pynoos & Eth, 1985; Pynoos & Nader, 1993). Symptoms may temporarily increase over the course of treatment as numbing and avoidance are reduced. The abreactive processing in individual sessions is usually followed by a sense of relief, animation, increased expression, and resolution of related symptoms.

The initial session (Pynoos & Eth, 1986) examines the child's experience and worst moment. The focus of this and subsequent sessions is tailored to the child's readiness and needs. Drawings, verbalizations, behaviors, assessment measures, and the reports of adults and friends give clues to areas of importance (Nader, 2001, in press; Nader & Mello, 2000). Treatment addresses the child's personal symbolism and personal experience of the trauma. Closure is achieved at the end of each session. When possible, school, family, and group work provide important supplemental supports for this treatment (Nader & Mello, 2000).

Play therapy utilizing corrective dénouement. Like trauma/grief-focused therapy, Lenore Terr's method includes multiple techniques in addition to play, artwork, recital of the experience and its precursors, and the therapist's well-timed interpretations (Terr, 1999, in press). Adjunct methods provided by well-trained clinicians may include (a) behavioral modification (e.g., relaxation and gradual exposure techniques); (b) cognitive-behavioral approaches (e.g., confronting the abuser in imagined scenarios); (c) medication for specific symptom relief (e.g., depression or panic); (d) group work (e.g., prevention groups after the hit and run death of one student); (e) lucid dreaming (e.g., to assist the child in correcting the end of a dream); (f) corrective dénouement; and (g) inspirational stories or videos of those who have recovered from similar traumas (e.g., for an amputee, a commercial of a male basketball player with artificial limbs; Terr, 1999, in press). Toward the end of play therapy treatment, play should have healthy, nontraumatic endings. When not ill-advised because of age or legal status, the youth is provided a documented factual description of the traumatic event. This method recognizes that, although treatment may follow three phases (abreaction, context, and correction), stages of treatment may be handled out of order on the basis of the child's needs.

In 1983, Terr described play therapy utilizing corrective dénouement for use with traumas for which a solution is possible. In this method, the therapist helps the youth to find, in retrospect, a real solution that might have avoided the trauma or stopped the assault. This procedure permits the youth to realize (a) that he or she could not have avoided the traumatic event because he or she did not know how, and (b) that he or she now has the coping skills to deal with a similar event. Dénouement play relieves fear and guilt. Some traumas, however, cannot be reworked in this way (e.g., natural disasters, catastrophic illness, or random unprovoked attacks).

Relationship-Focused Play Therapies

Several theorists believe that early attachment styles govern significant social ties and interactions throughout life (Bowlby, 1973; Main, Kaplan, & Casidy, 1985; Thompson, 1991). A secure attachment is adaptive and derives from the infant's confidence that help-seeking signals will receive prompt and appropriate adult response (Ainsworth, 1973; Bowlby, 1969, 1973; Thompson, 1991). Faulty attachment relationships may be the result of traumatic experiences. Preexisting disturbed attachment styles affect the youth's posttrauma interactions with a therapist and affect the course of recovery.

Single, chronic, and repeated traumatizing events may be characterized by, or may create, faulty attachment relationships. For example, a physically abused child may develop faulty attachment relationships with both parents (e.g., may feel unprotected by the nonabusive parent). Single-incident traumatic events can result in impaired functioning, feeling overwhelmed, prolonged separation, fear, anxiety, and misinterpretation of behaviors. Any of these occurrences can lead to patterns of child or parent behavior that seriously interfere with the attachment relationship. A parent might not be able to recognize or respond adequately to the child's needs; the child might not be able to adequately express needs or respond to the adult (Field et al., 1996; James, 1994). Parents who emotionally smother a child because of their posttrauma fears may ultimately contribute to significant attachment problems (James, 1994). Hostage situations may result in disturbed attachment relationships with the hostage taker (Ochberg & Soskis, 1982).

Young children who have been emotionally deprived or who have experienced serious trauma are often inhibited in their abilities to engage in symbolic play or fantasy (James, 1994). To benefit from relationship or other play therapy, some traumatized children must be taught how to play. James (1994) describes several methods of relationship-focused play therapy that address the faulty attachment relationship and the child's ability to play.

Beverly James' approach. James (1994) focuses on attachment relationships and situations in which adults alone or with their children can benefit from play therapy. Her method includes education, development of self-identity, assisting the child to tolerate and modulate affect, relationship building, and more. Among the techniques are positive touching, cozy family interactions and shared experience (e.g., singing together), changing negative behavior patterns, recognizing the meaning of behaviors, caregivers learning to stay in charge, and modeling by the therapist. The traumatic experience is explored with the child after the child feels secure and connected in the relationship and can cope with exploring the experiences.

Dynamic Play Therapy. This play therapy approach (Harvey, 1994) helps families to create play activities that enhance positive attachment bonds. Among its goals are the development of attunement, rhythm in interactions, and the ability to creatively problem solve. Parents and children play together using art, movement, drama, and video expression. Expressive activities are generated by the therapist or by family members. Simple group activities (e.g., rolling a ball back and forth or finishing a mural) can be extremely difficult for families lacking in mutual trust, healthy expression of feelings, and problem solving. Metaphors, images, props, and reframing are used to change patterns of interaction between parent and child. One activity can be played out into another in order to teach families to play with their problems. Dynamic Play Therapy highlights and reinforces natural qualities of play—such as naturalness, spontaneity, mutual attraction, physically involved expression, and transformative problem solving—while trying to engage parents and children in expressive, playful interactive activities. Talking, insight, and verbal understanding of problematic interactions are occasional aspects of the treatment method. Primarily, the method encourages complete physical interactions between parents and children in order to facilitate natural play and accomplish change.

Developmental Play Therapy. This therapy ensued from the needs of hospitalized severely disturbed young children who had not benefited from traditional "talk" therapy or other play therapies (Brody, 1994). The goal of this method "is to provide an environment in which the child can develop a core self by experiencing her physical body and the pleasure of her aliveness" (p. 235). Because caring touch initiates the attachment process in young children, this method focuses on physically touching, holding, carrying, and singing to the youngsters, and allowing them to touch the therapist as well. With awareness that she or he is being touched, and by whom, the child derives pleasure from being noticed and touched. The child generally then invites more contact, and by that invitation the attachment process begins. The therapist controls the activities, but restricts it only if the child is destructive or is hurting self or therapist. As a result of caring touch and of training parents that children need to be seen and touched, youths begin to relate to others, appetites improve and weight increases, and the maturation process resumes.

Group Play Therapy

Group play therapy has been used successfully with traumatized youths often in combination with individual treatment (Sweeney & Homeyer, 1999).

Group play therapy with abused children. Homeyer (1999) describes a group method used with abused children in conjunction with individual, family, and sibling therapies. Group members generally include children of the same gender, similar physical size, similar developmental age, and a balanced number of those who internalize versus those who externalize the trauma in behaviors. Group play therapy is contraindicated for youths who exhibit serious psychiatric disturbances, suicidal behavior, nonsuicidal self-mutilation, severe mood or thought disturbances, the ability to hurt others without remorse, or who were recently abused or sexually abused in a group.

Inasmuch as experiencing "failure" in the group setting can reinforce low self-esteem, feelings of powerlessness, victimization, and guilt, once the group begins to meet, changes in group composition may be needed.

Group play therapy for abused children addresses: (a) traumatic sexualization of behaviors; (b) stigmatization and isolation; (c) sense of betrayal; and (d) powerlessness, anger, fear, and guilt (Homeyer, 1999). The clinician uses feedback and supportive interpretation of behaviors to assist the child. The play therapist remains within the context of the youth's play. Although the child and the play therapist are actors on the stage of the child's design and direction, the play therapist enlarges the meaning so that the youth can hear the meaning of the story he or she is producing. Rather than a linear progression to treatment, the child moves through repeated cycles of testing the therapeutic relationship, readdressing the trauma, and protective distancing and denial. Limit setting is used with sexualized behaviors. For example, a child may engage in reenactment of aspects of his or her experience or, as trust and a therapeutic relationship develop, the child may struggle with the confusion between emotional intimacy and sexual intimacy. It is important to allow the child to set the pace for dealing with issues. Parent education, including warning of the need for periodic subsequent sessions, is used as a part of termination.

Directive Group Play Therapy. Leben's (1995) method has been used nationally and internationally by foster group homes and school behavioral management classes to assist children with attention-deficit/hyperactivity disorder (ADHD), low self-esteem, and/or traumatic emotions (in sexually traumatized children). The method includes 60 fast-paced structured and semi-structured games that are used for:

- assessment and diagnosis (e.g., creating a picture and telling a story);
- skill development (e.g., attention span, problem solving, imagination, math, and coordination);
- interactional abilities (e.g., social skills, positive touch, observation, respecting others' space, sportsmanship);
- emotional expression or release (e.g., anger catharsis, identifying feelings); and
- enhancing self-image (i.e., self-esteem, empowerment).

Facilitators provide enthusiasm, honest feedback, an accepting atmosphere, discipline, positive reinforcement, opportunities for successful experience, and good modeling.

Group process and dynamics, positive feedback, reinforcement, and a strong therapeutic relationship are used to change behaviors and beliefs. The therapist manages misbehaviors, teaches healthy interpersonal skills, and reinforces good values. The group process assists children's abilities to handle interpersonal conflicts and work as a team. Play therapy sessions include games selected to meet individual objectives for each child and one or two motivational games. Groups are modified to meet children's ongoing needs and to facilitate discussion. Children generally transfer skills learned in the group to other social situations (Leben, 1995).

Cognitive Behavioral Therapy

Behavioral therapists strive to change behaviors and thereby reduce distressing thoughts and feelings. Cognitive therapists first change thoughts and feelings, thereby improving functional behavior (March et al., 1999). How events are cognitively appraised and what one already knows can influence reactions to stressful, novel, or traumatic situations (e.g., Gunnar, Brodersen, Krueger, & Rigatuso, 1996; Howe, 1997). Theoretically, knowledge acquired throughout life is represented in memory in the form of abstract, generic knowledge structures, or "schemas" (Bartlett, 1932; Neisser, 1976; Siegel, 1996). Within an information-processing framework, PTSD is characterized by dysfunctional schemas in which the world is conceived of as indiscriminately dangerous and the self as totally incompetent to cope with stress. These schemas are thought to have emerged through "overaccommodation" of pretrauma assumptions that the world is a safe place and the individual is competent (e.g., Foa, Steketee, & Rothbaum, 1989; March et al., 1999).

Behavior therapists view traumatic stressors through classical conditioning theory. Within this theory the traumatic event is thought to act as an unconditioned stimulus that elicits a reflexive (unconditioned) response characterized by extreme fear and the perception of terror and helplessness. Traumatic reminders (conditioned stimuli including cognitive, affective, physiologic, and environmental cues) may elicit anxiety (a conditioned response), which should decrease with prolonged, repeated exposure in the absence of real threat. The child learns to reduce distress through cognitive and behavioral avoidance and/or anxiety-dampening rituals (e.g., reassurance seeking, instrumental conditioning). These anxiety-reducing behaviors stop the extinction of trauma-relevant anxiety (March et al., 1999). The Cognitive-Behavioral Therapy (CBT) therapist targets the distorted associations (stimulus-stimulus and stimulus-response) as well as dysfunctional evaluations and beliefs (Foa & Rothbaum, 1997; March, 1998). Recounting the traumatic memory decreases associated anxiety, thus allowing its reorganization (Foa & Rothbaum, 1997). Treatment progress is reflected in an increasingly coherent narrative of the trauma that can be more readily integrated with the victim's existing schemas (March et al., 1999). CBT combines cognitive (e.g., psychoeducation, cognitive restructuring) and behavioral techniques (e.g., behavior management, gradual exposure) to assist youth.

Individual Trauma-Focused Cognitive Behavioral Therapy

An individual trauma-focused CBT method has been described for school-age and adolescent youths by Judy Cohen of Allegheny General Hospital in Philadelphia

(Nader, 2001). The method focuses on the treatment of sexually abused children with parallel approaches for youths exposed to other traumatic stressors (American Academy of Child and Adolescent Psychiatry Work Group on Quality Issues, 1998; Cohen et al., 1997; Cohen, Berliner, & Mannarino, 2000; Cohen & Mannarino, 1993, 1996, 1997; Cohen, Mannarino, Berliner, & Deblinger, 2000; Deblinger & Heflin, 1996). Treatment includes exposure, cognitive restructuring, behavior management, psychoeducation, stress management, and safety skills (Cohen, 1999). For example, "gradual exposure" techniques encourage the child to describe abusive episode(s) repeatedly and with increasing detail. Over the course of several sessions, the child reviews and adds to a book or artwork. The goal is to decrease PTSD avoidant symptoms and to break the association of the abuse and negative emotions such as fear (Cohen, Berliner, & Mannarino, 2000; Cohen, Mannarino, Berliner, & Deblinger, 2000).

Caretaking adults other than a perpetrator of abuse (unless the offender has received counseling and is able to acknowledge appropriate responsibility) may benefit from a number of treatments. Parent interventions also include exposure, cognitive restructuring, behavior management, psychoeducation, stress management, and safety skills. For example, exposure techniques with the parent in individual sessions include hearing the parent's description of the abuse and then sharing (with the child's permission) the child's descriptions of what happened. The child's book or artwork is shared with the parent in progressive sessions until the parent is able to tolerate direct discussion of the child's experiences. If progress is adequate, joint sessions (Deblinger & Heflin, 1996) permit the child and parent to directly discuss what the child experienced, the parent to model adaptive coping to the child, and the parent to provide appropriate emotional support. The goal is to enhance communication between parent and child so that the child will feel able to go to the parent if future symptoms or traumatic events should occur. These techniques should NOT be used in order to elicit information for forensic purposes. Because gradual exposure may result in a transient worsening of symptoms in some children, this technique should be used with great caution in youths who are acutely suicidal or actively using drugs or alcohol (Cohen, Berliner, & Mannarino, 2000; Cohen, Mannarino, Berliner, & Deblinger, 2000).

Eye Movement Desensitization Reprocessing (EMDR)

Francine Shapiro developed EMDR in 1987 when she discovered that upsetting thoughts faded when the eyes moved spontaneously from side to side (Chemtob, Nakashima, Hamada, & Carlson, in press; Chemtob, Tolin, van der Kolk, & Pitman, 2000; Greenwald, 1998, in press; Puffer, Greenwald, & Elrod, 1998; Shapiro, 1989a, 1989b). A great deal of praise (Greenwald, 1993; Lovett & Shapiro, 1999; Pellicer, 1993; Shapiro, 1991b, 1995) and concern has followed the advent of this treatment method (Coco & Sharpe, 1993; Greenwald, 1996; Herbert & Meuser, 1992; Lohr et al., 1992; Metter & Michelson, 1993; Shapiro, 1991a). It has been adapted for youths whose trauma, loss, or stressful experiences have resulted in symptoms or problems (Greenwald, 1994, 1998; Lovett & Shapiro, 1999; Pellicer, 1993). Whether or not they result in PTSD, trauma or loss may render a youth vulnerable to subsequent stressors, especially those with the same theme or issue. Any incompletely processed trauma or bereavement memory that may contribute to a youth's problems or symptoms may become the focus of EMDR (Greenwald, 1994).

EMDR procedures are complex and variable. In general, the child is asked to focus intensely on a traumatic memory while moving the eyes rapidly from side to side, by visually tracking the therapist's moving hand. This seems to render the traumatic memories accessible to internal healing resources for work-through and integration. Treatment may include many "sets" of eye movements (10 seconds to a minute or more). The focus changes according to the child's status. Following a set of eye movements, the therapist "checks in" with the child in order to monitor progress and to refocus for the next set of eye movements. Subjective Units of Disturbance Scale (SUDS) ratings are taken at intervals. The child may experience imaginal reexperiencing, a progression of emotional responses, decreased distress, reduced vividness of images, physiological release (e.g., of tension), and the supplanting of negative self-statements and beliefs (Greenwald, 1994).

Some clinicians use a variety of adjunct treatments with EMDR (e.g., parent training, educational accommodations, behavior modification, and medication) to stabilize the environment and create conditions for healing and increased successful functioning (Greenwald, 1994; Terr, in press). EMDR's purpose is to bring past trauma or loss memories to resolution. The preferred approach is to identify all possibly relevant memories (which may have contributed to the problem) and proceed in chronological order from earliest to latest. Although resolution of earlier trauma or bereavement-related memories may render the later memories less important, they are nevertheless addressed (R. Greenwald, personal communication, April 18, 1999).

Trauma-Focused Coping (TFC)

TFC is a cognitive-behavioral group therapy treatment for youths traumatized by single-incident traumas; it includes psychoeducation, cognitive therapy, exposure-based behavior therapy, generalization training, and relapse prevention (March et al., 1999; March, Amaya-Jackson, Murry, & Schulte, 1998; March, Amaya-Jackson, Terry, & Costanzo, 1997). Derived from the child and adult literature on evidence-based treatment for adult and pediatric posttraumatic reactions, TFC follows both cognitive (restructuring) and behavioral (exposure) principles. Treatment progress is reflected in an increasingly coherent narrative of the trauma that can be more readily integrated with the victim's existing schemas. Once a memory is so processed, the victim is able to conceive of the trauma as a distinct event rather than as a global representation and, thus, to discriminate between danger and safety. The self is then viewed as competent (March et al., 1999; J. March, personal communication, August 25, 1999).

TFC involves 14 weekly sessions. Even if indirectly related to PTSD, home, school, and other psychiatric problems (unless they constrain treatment of PTSD) are not the focus of treatment. Secondary symptoms often remit once a child has experienced some success in "bossing back" PTSD. Nevertheless, when an intervention or task is not working, revision is made. The therapist peppers the group members with questions about their experiences "bossing" or being "bossed around" by PTSD (March et al., 1999).

The first few sessions define the treatment process, build rapport, enlist the child's cooperation in the treatment process, and lay the groundwork for the child to think differently about PTSD. Treatment begins with psychoeducation and cognitive therapy before moving to more exposure-based interventions. Each session lasts approximately 50 to 60 minutes and includes a statement of goals, review of the preceding week, provision of new information, therapist-assisted practice, practice homework for the coming week, and monitoring procedures. During the middle and end of treatment, 30 to 40 minutes of each session may be spent in therapist-assisted exposure tasks. As a reward for participating in the hard work of exposure, the end of a session may also be allocated to a social reward, such as playing a game or talking about something besides PTSD (March et al., 1999).

Multimodal Treatment Methods

Many treatment methods use a number of adjunct treatments to supplement the main method. Multimodal treatment methods use a combination of methods within a series of overlapping treatment phases.

Family Treatment for Abuse

Family therapy has been used as a main component of the treatment of sexually abused children (Gorham, 1997; Madanes, 1990; Sgroi, 1982, 1988) and as an adjunct treatment for single-incident traumas (Nader & Mello, 2000; Pynoos & Nader, 1988a). The treatment described below (taught by Mary Jo Barrett, Director of the Center for Contextual Change in Skokie, Illinois) is based on a family treatment approach combined with other methods (e.g., play therapy; M.J. Barrett, personal communication, July 20, 1999). Known as The Multiple Systems Model, this treatment offers a systematic framework that divides the therapeutic process into stages and gives the clinician clear guidance in the face of the child's anxiety and overwhelming needs. This method calls for the treatment of abuse victims, nonoffending parents, nonabused siblings, and perpetrators (Trepper & Barrett, 1986). The type of intervention (individual, family, or group) and the frequency of the sessions is determined both by the needs of the child and family and by the assessment of the clinician. To assess the impact of the trauma, clinicians determine the nature of the event, the context of the abuse, and the meaning given to the event(s) (Trepper & Barrett, 1986, 1989).

The Multiple Systems Model is organized into three stages. Treatment does not proceed linearly; however, the flow tends to occur within the boundaries of these stages (M. J. Barrett, personal communication, July 20, 1999).

Stage I: Creating a Context for Change. This stage assesses and creates safety for the family and the victim within the context of treatment and outside of treatment. Measurement tools and interviews are utilized during evaluation. Assessment of individual and familial interactions, strengths, and difficulties takes place over time. The clinician continually strives to build a team with the family, including the child, and all professionals involved (e.g., social service, judicial, and legal). The goal is to help children and families rebuild a sense of power and control in their lives. An ongoing treatment plan and goals are then designed and agreed upon with the entire community team and the family.

Stage II: Challenging Patterns and Expanding Realities. Individual, family, play, and group therapy are used with both youths and adults. The team helps both individuals and families explore the patterns that created and maintained the sexual abuse. It helps them to create alternative behaviors, thoughts, and feelings.

Stage III: Consolidation. This is the relapse-prevention stage. The family and the team review what they have learned and changed. Together they predict where they might have difficulties in the future. Based on current strengths, they design a plan to help themselves with future difficulties and prevention of relapse.

Treatment of Inner City Children and Adolescents

Post-Trauma Child Therapy (P-TCT) targets issues related to exposure, violence, ethnicity, and culture that operate interactively for youths traumatized multiple times by repeated exposure to violence (Parson, 2000). Urban violence traumatic stress response syndrome (Parson, 1994) features five major dimensions: (a) damaged sense of self (e.g., sense of ineffectualness) and confused self-identities (e.g., as both victim and perpetrator); (b) severed attachment bonds (e.g., distrust of family, friends, neighbors, and society); (c) cognitive stress response (i.e., cognitive regressions); (d) emotional stress response (e.g., profound intolerance for strong affect, ongoing depression and despair, guilt and shame, fears and anxiety, anger and belligerence); (e) moral stress response and distortion of ethnocultural values (e.g., “vendetta mentality,” see Garbarino, Kostelny, & Dubrow, 1991, p. 379).

P-TCT is a multiphasic trauma treatment model (Parson, 1984, 1994, 1996a, 1996b, 1997) that emphasizes child and family education, expression of affects, deconditioning of negative affects, symptom management, coping augmentation, reversing cognitive distortions while facilitating self-identity, and relational development (Parson, 1996a, 1996b, 1997). Treatment addresses fragmented, incomplete, and distorted memories. Each of four phases has specific goals for processing trauma memories, but each takes into consideration that each child and family are different.

Phase 1: Pretherapy. This phase includes modeling, role-play, relevant videotape programs, and other psychoeducational techniques as well as establishing goals, benefits, focus, and methods.

683

Phase 2: Stabilization. This phase includes cognitive-behavioral stress management (i.e., stress management/relaxation training, deconditioning of negative affects, biofeedback, systematic restructuring of assumptions and, when indicated, psychopharmacology and/or residential treatment). Self-instructional training in the following three steps is also offered: (a) negative thinking is explored; (b) the child learns how to generate incompatible thinking, facilitated by overt, positive self-statements and later repeated subvocally; and (c) behavioral rehearsal (ensuring steady development of coping and mastery skills).

Phase 3: Return to Scene. When a trusted therapeutic relationship has developed and the child has mastered a relaxation procedure, EMDR, cognitive, and dynamic procedures are used at the actual scene of the trauma.

Phase 4: Completion and Integration of Self. Individual and play modalities, as dictated by the child's developmental needs, are offered. Psychodynamic approaches (e.g., transference, dream interpretation) are used to facilitate the child's capacity to tolerate and integrate powerful trauma emotions.

Successful treatment increases control and improves sense of self. It also reduces fragmentation and helplessness. The child learns to trust, to increase coping, to take responsibility for personal emotions and actions, and achieves integration and growth (including repaired attachments; Parson, 1994, 1996a, 1996b, 1997).

Methods Addressing Specific Symptoms

A number of treatments address specific posttrauma symptom groups. Below are treatments for reenactment and risk-taking, arousal symptoms, and dissociative symptoms.

Trauma Reenactment and Risk-Taking Behaviors

Psychoeducational groups have been used as important adjunct methods for traumatized youths and their families (Hazzard, 1993; Nader & Mello, 2000). The following method elaborated by Ann Marie Glodich and Jon G. Allen of The Menninger Clinic Child and Family Center (Allen, Kelley, & Glodich, 1997; Glodich & Allen, 1998; A. M. Glodich, personal communication, June 30, 1999; Glodich, 1999) has been used with adolescents exposed to ongoing violence and abuse. Reenactment and risk-taking behaviors are common among traumatized youths. Interventions that target reenactment and risk-taking behaviors may avert traumatic reexposure and increased symptomatology. Traumatic memories are not specifically addressed; description or detailed discussion of traumatic events are not elicited. Participants are provided factual information when they discuss specific events. Coping strategies are suggested to help participants develop a cognitive framework for processing the events.

The Menninger Child and Family Center group protocol is specifically designed to provide education about the effects of trauma and violence and the connection of these effects to reenactment and risk-taking behaviors and to decrease reenactment and risk-taking behaviors. Each session is structured with a specific focus and a task. Key topics are: (a) prevalence of violence and trauma; (b) violence-related trauma and PTSD; (c) defenses; (d) avoiding further trauma and violence; (e) reexposure to trauma, reenactment, and diffusing violence to avoid further trauma; (f) combating helplessness; (g) the role of family in combating helplessness; and (h) review with a specific focus on reducing reenactment and risk-taking behaviors. Participants are encouraged to talk about as much of their experience as they wish, but they are not required to contribute their own personal experiences. Participants are not required to talk at all if they do not feel comfortable doing so. Each session begins and ends with antiviolence music (selected by the group leaders or participants). Two sessions feature role-play (A. M. Glodich, personal communication, June 30, 1999).

Treatment for Dissociative Disorders

Dissociative Identity Disorder (DID) and dissociative symptoms have been associated with severe stressors such as chronic physical and sexual abuse, chronic medical problems requiring repeated surgical procedures, and imitation of family dissociative disorders (Coons, 1996; Dell & Eisenhower, 1990; Malenbaum & Russell, 1987; Peterson, 1996; Siegel, 1996; Silberg, 1998a, 1998b). One main treatment philosophy focuses on shifting traumatic memories from implicit, nondeclarative memory into explicit, declarative memory, thus modulating the experience and putting it into the perspective of other life experiences (Peterson, 1996; Seigel, 1996). It includes some or all of the following: (a) establishing safety, (b) developing a working relationship with the alternate personalities (alters), (c) hearing their stories, (d) contracting, (e) developing communication between the alters, (f) working toward resolution and integration of personalities, and (g) developing new coping skills (Kluft, 1986, 1990; Peterson, 1996; Putnam, 1986, 1989a, 1989b; Siegel, 1996). A contrasting treatment philosophy is embodied in Joyanna Silberg's treatment method (J. L. Silberg, personal communication, May 4, 1999; Silberg, & Waters, 1998; Silberg, 2001), which minimizes focus on traumatic memories and emphasizes the child's recognizing and taking responsibility for the emotions and actions of each part of self (alter). Parts of the mind seen as separate are perceptually and experientially redefined. Clinicians evaluate opposing feelings (or alternate ideas) and encourage resolution. It is often because of the fear of facing what seems like an unresolvable emotional conflict that dissociative states result. Youths, who may have learned automatic coping strategies for facing conflicting feelings, learn that no dilemma is unresolvable (Silberg, personal communication, May 4, 1999).

Silberg's treatment method is based on a multilevel intervention strategy where the child's emerging self theories, the family system, and the child-therapist interaction system are intervention targets. Treatment components seek to change interaction patterns that promote dissociative coping by teaching parents to validate youths' feelings; promoting communication that is more open; reducing (e.g., by clinician, parents, teachers, and siblings) undue interest or fascination in separate personalities and their actions; discouraging relating directly to the parts of self (alters); encouraging reacting consistently and acceptingly with all self-states—no matter what part of the child presents; assuming the child can recover what was shared in a different state; and encouraging the child to keep alters private outside of the therapeutic setting.

The therapist is careful not to reinforce or encourage a fragmented view of the self. For example, use of terms like "switching" and "alters" conveys a reality to these experiences that they may not merit. Silberg recommends using the language of the child or helping the child find language to describe experiences with words that suggest similarities to normal phenomena. For example, the therapist might name the function and emphasize that it is indeed only a part of the self by saying, "That part of you that you call Doug, that helps you with getting angry." Over time, the therapist can omit the name and refer only to "the part of you that gets angry" (Silberg, 1998a). Every opportunity is used to point out gently and to reinforce how nice it will be when wholeness is achieved (e.g., additional opportunities and increased trust, increased privileges as continuity of consciousness develops; Silberg, 1998a).

The focus of treatment is determined by a careful assessment of how much of the dissociative behavior is maintained by internal conflict, perceptions of ongoing threats, family patterns that sustain, secondary gains, and idiosyncratic self-theories. Treatment addresses all factors that maintain the dissociative behavior and self-conception at the expense of adaptive coping. Traumatic memories are dealt with only on an "as needed basis." If a child's continued regression into a childlike state is related to a cue that reminds a child of the trauma, it is important to evaluate that memory, detoxify it, and sever any cues that automatically elicit reexperiencing of that event. Sometimes this best occurs with supportive, nurturing parents in the therapy room, who can listen to a child's account of a past trauma, provide reassurance that this will not reoccur, and provide the soothing that the child may have missed earlier. The processing of these traumatic moments within the context of a safe and loving relationship is seen as the best way to detoxify their conditioned effects (Silberg, 1998a, 1998b).

Arousal Symptoms

Tactile stimulation with pressure (massage therapy) has been associated in general with the reduction of neurochemicals that increase arousal (Field et al., 1996). Increased cortisol levels are associated with stress, fear, and anxiety. There is some indication that a pattern of elevated cortisol levels may be passed on to offspring (Suomi & Levine, 1998).

Although studied only at the beginning and end of treatment, a reduction in cortisol levels, anxiety, depression, and trauma levels were associated with the use of massage therapy for youths during hospitalizations (Field et al., 1992) and following a hurricane (Field et al., 1996). For inpatient adolescent psychiatric patients, after massage therapy for one-half hour a day for a week the youths had lower levels of depression, anxiety, and stress hormones (cortisol and norepinephrine) and showed more organized sleep patterns and more appropriate behavior (Field et al., 1992; Touch Research Institute, 1999). Each massage therapy session included 30 minutes of back massage 2 times per week over a 1-month period. The massage entailed 5-minute periods of moderate pressure and smooth stroking movements for each of three regions (15 minutes total): up and down the neck; from the neck across the shoulders and back to the neck; and along the vertebral column from the neck to the waist and back to the neck. This same 15-minute sequence was repeated twice in its entirety (total session of 30 minutes). During the examination of this method, youths were asked to remain still and quiet during the session and were told that the massage would help them relax. The massage therapist remains silent during the sessions (Field et al., 1996). It is unknown whether the reduction in symptom levels persists after the period in which massage is given. It may, however, provide an important supplemental treatment to reduce arousal symptoms such as sleep disturbance, anxiety, and irritability that affect daily life and treatment.

Directions for Future Research

We have become fairly adept at measuring the symptoms of PTSD in youths (Carlson, 1997; Nader, 1997a; Stamm, 1996). We have successfully reduced PTSD symptoms simply by skillfully interviewing youths about their traumatic reactions (Nader, 1997a). Arousal symptoms and cortisol levels have been reduced at least temporarily by massage therapy (Field et al., 1996). Prevention of future difficulties, however, may include more than resolving the symptoms of, and associated with, PTSD. For example, trauma may result in increased readiness to arousal or increased reactivity (van der Kolk & Sapporta, 1991). In addition to a loss in impulse control, abused children (or children exposed to other repeated violence) may develop qualities such as perceptual readiness to attribute hostility to others and a large repertoire of highly accessible aggressive responses. This occurs with knowledge that aggression can lead to positive consequences for the attacker (Dodge, Bates, Pettit, & Valente, 1995). Reactivity may be biochemically inherited, resulting in highly reactive offspring (Suomi & Levine, 1998). Moreover, there is evidence that children of traumatized individuals have increased vulnerability to, for example, future traumatization, psychological difficulties, and increased symptoms when exposed to traumatic events (Danieli, 1998; Nader, 1998; Soloman, Moshe, & Mikulincer, 1988). Some of these symptoms may abate with the resolution of PTSD symptoms (March et al., 1999); others may require additional measures. If, at the end of treatment, the clinician and child have not uncovered and resolved specific traumatic moments or emotions, these emotions may translate into repeated complexes of behavior and emotions (behavioral patterns, life scripts, or dramas; Nader, 1997b, 2001).

Many questions remain regarding the vulnerabilities and patterns of behavior engendered by traumatic experiences. We need information about the long-term consequences of trauma related to personality, temperament, or attachment style (Berens

& Nardi, 1999; Chess & Thomas, 1991; James, 1994; Nader, 2001). There is limited evidence, for example, that youths with preexisting conduct disturbances may react differently than others to traumatic experiences in which they are not injured (Nader & Pynoos, 1993; Pynoos et al., 1987). When therapies condition responses to memories or condition behavior rather than reprocessing traumatic memories, do the memory impressions become suppressed over time? There is evidence that unresolved trauma responses may be later expressed in patterns of behavior (e.g., overt or disguised reenactments such as frigidity or promiscuity after molestation), life scripts (e.g., any stress or other traumatic reminder leads to disguised reexperiencing or reenactment such as workplace stress leading to trembling and a desire to flee), psychological difficulties (e.g., moderate to severe anxiety and/or depression) or violence (e.g., killing peers at school) (Herman, 1992; Nader, 2001) Patterns of behavior traumatically ingrained and practiced over years may be more difficult to transform. We must first learn to measure all of the results of trauma before we can determine (a) if the return of a sense of competence and control modulates or counteracts patterns and problems through adulthood; (b) what vulnerabilities stay dormant until triggered by the right set of circumstances or reminders; and (c) how child and family characteristics interact with the long-term results of childhood trauma (Nader, 2001).

Measuring Outcomes

A number of factors make it problematic to assess the results of treatment (Nader, 2001). Studies of treatment methods often do not include the most severe cases (Friedrich, 1996) and have not examined many child variables (see General Treatment Issues discussed earlier in this chapter). Measuring outcomes is fraught with difficulties, including issues of time, contamination, selection, and identifying true measures of effectiveness. We can only know the true efficacy of our treatment methods by examining children over years into adulthood. Over periods of years, however, individuals are affected by numerous influences. In most cases, treatment programs include adjunct methods considered important to full recovery; any one component is difficult to assess over years. For methods used with youths identified from a large population, if small numbers agree to treatment, we do not know how the larger group would have fared in the treatment (or whether only those who would benefit from the treatment agree to it).

Patterns of reporting affect outcome measurement. In the year following treatment, youths may respond to their wishes to have recovered; the expectations of others (peers, parents, teachers and clinicians); desires to be pleasing to others; and their pleasure at having made some recognizable successes from treatment. In studies of children exposed to violence or disaster, there is some evidence that, one or two years after trauma intervention, some children report fewer symptoms for themselves than trained clinicians, teachers, and/or parents report for them (Nader, 1991, 1997a, 2001; Pynoos & Nader, 1993). Moreover, it is possible that, with some time and distance from treatment, youths who have undergone treatment may become better at analyzing their emotional responses and at reporting symptoms (Friedrich, 1996). Youths with reduced denial, increased maturity, growing confidence, and heightened analytic and reporting skills may report more symptoms than they had earlier reported at specific intervals during treatment (Friedrich, 1996; Nader, 1997b) and 8 to 10 years after treatment has ceased.

Long-term studies are needed both for assessment of treatment outcomes and assessment of outcome measures. Multiple measures exist for PTSD. Thus far, we are less adept at measuring other important aspects of long-term childhood traumatic response (e.g., child-specific vulnerabilities, patterns of behavior and interaction). It is essential that we learn to identify and assess the results of trauma in addition to PTSD and associated features. Goal attainment scaling (Hogue, 1994) has been a useful individualized, treatment-specific method of measuring specific goals accomplished by therapy (Friedrich, 1996). Accurately identifying the issues that will affect the long-term results of treatment is a prerequisite to the effectiveness of this method of measuring outcome. Over time, children's symptoms, no longer overt, may become embedded in symbolic play or activity (Nader & Pynoos, 1991), personality, interactional styles, and patterns of behavior. Specific traumatic impressions may eventually translate into patterns of action and thought that affect choices, quality of life, and behaviors (Nader, 2001; Nader & Pynoos, 1991). The link between specific traumatic symptoms and school violence has underscored our need to learn more about this connection in the treatment of traumatic response (American Academy of Child and Adolescent Psychiatry, 1999; American Psychological Association, 1999; National School Safety Center, 1999).

Conclusions

Used effectively, the innovative treatment methods described in this chapter can reduce symptoms of PTSD, reduce or prevent the escalation of depression and/or other trauma-associated symptoms, and enhance or help to restore the child's confidence, competence, and control. These treatments also provide an ally in the therapist and a sense that the child is not alone. All methods require a period of training and supervision in order to be effectively used and to prevent harm to children.

We know far less than we need to know about the effectiveness of our treatment methods. For example, we do not yet know whether different treatment methods may be most effective when used by clinicians with specific styles and attitudes, or with youths who have specific qualities and/or experienced specific types of trauma. New measures and methods are needed to identify specific aspects of the child, the experience, and additional variables that influence the long-term consequences of trauma and treatment. We need to know more about the interplay of the child's history (e.g., attachments, family, and school life); trauma symptoms (e.g., increased reactivity; changed attitudes); aspects of the specific event or ongoing exposures (e.g., intense traumatic impressions, the personal or impersonal nature of the assault whether by nature, person, or nation); characteristics of the child (e.g., temperament or personality style); and other variables. When we can identify and assess these additional variables over time, we will have clearer and more thorough information about the results of interventions and the needs of traumatized youths.

Acknowledgments

I extend sincere appreciation to Dr. Joyanna Silberg, Dr. Judith Cohen, Dr. John March, Dr. Erwin Parson, Dr. AnnMarie Goldich, Dr. Rick Greenwald, and Dr. Mary Jo Barrett for the materials they provided for this chapter. I am sincerely grateful for the kind assistance in reading, gathering materials and information, typing, and editing provided by Dr. John P. Wilson, Dr. Fred Lerner, Dr. Sam Nader, Dr. Linda Berens, Dr. Christine Mello, Liz Hahn, Jackie George, Marilee Conant, Allison Spencer, Sheena Staff, and Chelsea Oldroyd.

References

Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In: B. M. Caldwell & H. Ricciuti (Eds.), *Review of child development research* (Vol. 3, pp. 1-94). Chicago: University of Chicago Press.

Allen, J. G., Kelly, K. A., & Glodich, A. M. (1997). A psychoeducational program for patients with trauma-related disorders. *Bulletin of the Menninger Clinic, 61*, 222-239.

American Academy of Child and Adolescent Psychiatry. (1999). *Understanding violent behavior in children and adolescents*. Available Online: www.aacap.org/publications/factsfam/behavior.htm

American Psychological Association. (1999). *Warning signs of teen violence*. Available Online: www.APA.org

Auerbach, S. M., & Spirito, A. (1986). Crisis intervention with children exposed to natural disasters. In S. M. Auerbach & A. L. Stolberg (Eds.), *Crisis intervention with children and families* (pp. 191-202). Washington, DC: Hemisphere.

Axline, V. M. (1969). *Play therapy*. New York: Ballantine Books.

Bartlett, F. C. (1932). *Remembering: A study in experimental and social psychology*. New York: Macmillan.

Berens, L. V., & Nardi, D. (1999). *The 16 personality types: Descriptions for self-discovery*. Huntington Beach, CA: Telos Publications.

Bowlby, J. (1969). *Attachment and loss. Vol. 1: Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss. Vol. 2: Separation*. New York: Basic Books.

Brody, V. (1994). Developmental play therapy. In B. James (Ed.), *Handbook for treatment of attachment-trauma problems in children* (pp. 234-239). Lexington, MA: Lexington Books.

Carlson, E. B. (1997). *Trauma assessments*. New York: Guilford Press.

Chard, K. M. (1994). *A meta-analysis of post-traumatic stress disorder treatment outcomes of women survivors*. Unpublished doctoral dissertation, Indiana University, Bloomington, IN.

Chemtob, C. M., Nakashima, J., Hamada, R., & Carlson, J. (in press). Brief treatment for elementary school children with disaster-related PTSD: A field study. *Journal of Clinical Psychology*.

Chemtob, C. M., Tolin, D. F., van der Kolk, B. A., & Pitman, R. K. (2000). Eye movement desensitization and reprocessing. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 139-154). New York: Guilford Press.

Chess, S., & Thomas, A. (1991). Temperament. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 145-159). Baltimore: Williams & Wilkins.

Clement, P.W. (1996). Evaluation in private practice. *Clinical Psychology: Science and Practice, 3*, 146-159.

Coco, N., & Sharpe, L. (1993). An auditory variant of eye movement desensitization in a case of childhood post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 24*, 373-377.

Cohen, J. (1999). *Treatment of traumatized children* (Trauma Therapy Audio Series). Thousand Oaks, CA: Sage Publications.

Cohen, J., & American Academy of Child and Adolescent Psychiatry Work Group on Quality Issues. (1998). Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry Supplement*, 37(10), 4S-26S.

Cohen, J. A., Berliner, L., & Mannarino, A. P. (2000). Treatment of traumatized children: A review and synthesis. *Journal of Trauma, Violence and Abuse*, *1*, 29-46.

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (1997). Treatment of PTSD in sexually abused children (Funded grant application). National Institute of Mental Health, 1R10 MH55963.

Cohen J. A., & Mannarino A. P. (1993). A treatment model for sexually abused preschoolers. *Journal of Interpersonal Violence*, 8, 115-131.

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 42-50.

Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, 1228-1235.

Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive behavioral therapy: An empirical update. *Journal of Interpersonal Violence*, *15*, 1203-1223.

Combrinck-Graham, L. (1991). Development of school-age children. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 157-265). Baltimore: Williams & Wilkins.

Coons, P. M. (1996). Clinical phenomenology of 25 children and adolescents with dissociative disorders. *Child and Adolescent Psychiatric Clinics of North America*, 5, 361-374.

Danieli, Y. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.

Deblinger, E., & Heflin, A. H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach*. Thousand Oaks, CA: Sage Publications.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, *1*, 310-321.

Dell, D. F., & Eisenhower, J. W. (1990). Adolescent multiple personality disorder: A preliminary study of eleven cases. *Journal of the American Academy of Child & Adolescent Psychiatry*, 29, 359-366.

Delunas, E. (1992). *Survival games personalities play*. Carmel, CA: Sunflower Ink.

Dodge, K. A., Bates, J. E., Pettit, G. S., & Valente, E. (1995). Social information-processing patterns partially mediate the effect of early physical abuse on later conduct problems. *Journal of Abnormal Psychology*, 104, 632-643.

Esman, A. H. (1983). Psychoanalytic play therapy. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 11-20). New York: Wiley.

Field, T., Morrow, C., Valdeon, C., Larson, S., Kuhn, C., & Schanberg, S. (1992). Massage reduces anxiety in child and adolescent psychiatric patients. *Journal of American Academy of Child & Adolescent Psychiatry, 31*, 125-131.

Field, T., Seligman, S., Scafidi, F., & Schanberg, S. (1996). Alleviating posttraumatic stress in children following Hurricane Andrew. *Journal of Applied Developmental Psychology, 17*, 37-50.

Foa, E. B., & Rothbaum, B. O. (1997). Behavioural psychotherapy for post-traumatic stress disorder. *International Review of Psychiatry, 1*, 219-226.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualization of PTSD. *Behavior Therapy, 20*, 155-176.

Friedrich, W. N. (1996). Clinical considerations of empirical treatment studies of abused children. *Child Maltreatment, 1*, 343-347.

Friedrich, W. N., Luecke, W. J., Beilke, R. L., & Place V. (1992). Psychotherapy outcome of sexually abused boys: An agency study. *Journal of Interpersonal Violence, 7*, 396-409.

Freud, A. (1965). *Normality and pathology in childhood.* New York: International Universities Press.

Garbarino, J., Kostelny, K., & Dubrow, N. (1991). What children can tell us about living in danger. *American Psychologist, 46*, 376-383.

Gil, E. (1991). *The healing power of play: Working with abused children.* New York: Guilford Press.

Gil, E. (1998a). *Essentials of play therapy with abused children.* New York: Guilford Press Video Publications.

Gil, E. (1998b). *Play therapy for severe psychological trauma.* New York: Guilford Press Video Publications.

Glodich, A. M. (1999). *Psychoeducational groups for adolescents exposed to violence and abuse: Assessing the effectiveness of increasing knowledge of trauma to avert reenactment and risk-taking behaviors.* Unpublished doctoral dissertation, Smith College School for Social Work, Northampton, MA.

Glodich, A. M., & Allen, J. G. (1998). Adolescents exposed to violence and abuse: A review of the group therapy literature with an emphasis on preventing trauma reenactment. *Journal of Child and Adolescent Group Therapy, 8*, 135-155.

Goenjian, A. K., Karayan, I., Pynoos, R. S., Minassian, D., Najarian, L. M., Steinberg, A. M., & Fairbanks, L. A. (1997). Outcome of psychotherapy among early adolescents after trauma. *American Journal of Psychiatry, 154*, 536-542.

Gorham, E. L. (1997). Sixteen-step strategic family therapy for the treatment of child sexual abuse: A treatment adaptation and case example. *Psychotherapy in Private Practice, 16*, 21-37.

Greenwald, R. (1993). *Using EMDR with children.* (Available with formal training from P.O. Box 51010. Garden Grove, CA 93950-6010)

Greenwald, R. (1994). Applying eye movement desensitization and reprocessing (EMDR) to the treatment of traumatized children: Five case studies. *Anxiety Disorders Practice Journal, 1*, 83-97.

Greenwald, R. (1996). The information gap in the EMDR controversy. *Professional Psychology: Research and Practice, 27*, 67-72.

Greenwald, R. (1998). EMDR: New hope for children suffering from trauma and loss. *Clinical Child Psychology and Psychiatry, 3*, 279-287.

Greenwald, R. (in press). Motivation – Adaptive Skills – Trauma Resolution (MASTR) therapy for adolescents with conduct problems: An open trial. *Journal of Aggression, Maltreatment, and Trauma.*

Gunnar, M. R., Brodersen, L., Krueger, K., & Rigatuso, J. (1996). Dampening of adrenocortical responses during infancy: Normative changes and individual differences. *Child Development, 67*, 877-889.

Harvey, S. (1994). Dynamic play therapy: Creating attachments. In B. James (Ed.), *Handbook for treatment of attachment-trauma problems in children* (pp. 222-233). Lexington, MA: Lexington Books.

Hazzard, A. (1993). Psychoeducational groups to teach children sexual abuse prevention skills. *Journal of Child and Adolescent Group Psychotherapy, 3*, 13-23.

Heras, P. (1992). Cultural considerations in the assessment and treatment of child sexual abuse. *Journal of Child Sexual Abuse, 1*, 119-132.

Herbert, J. D., & Meuser, K. T. (1992). Eye movement desensitization: A critique of the evidence. *Journal of Behavior and Experimental Psychiatry, 23*, 169-174.

Herman, J. (1992). *Trauma and recovery.* New York: Basic Books.

Hogue, T. E. (1994). Goal attainment scaling: A measure of clinical impact and risk assessment. *Issues of Criminological and Legal Psychology, 21*, 96-102.

Homeyer, L. (1999). Group play with sexually abused children. In D. S. Sweeney & L. Homeyer (Eds.), *The handbook of group play therapy* (pp. 299-318). New York: Jossey-Bass.

Howe, M. L. (1997). Children's memory for traumatic experiences. *Learning and Individual Differences, 9*, 153-174.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children.* Lexington, MA: Lexington Books.

Kalff, D. (1980). *Sandplay.* Santa Monica, CA: Sigo.

Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry, 25*, 223-237.

Kluft, R. P. (1986). Treating children who have multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 79-105). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1990). *Incest-related syndromes of adult psychopathology.* Washington, DC: American Psychiatric Press.

Lehmann, P., & Coady, N. F. (Eds.). (in press). *Theoretical perspectives for direct social work practice: A generalist-eclectic approach.* New York: Springer Publishing.

Leben, N. (1995). *Directive group play therapy: 60 structured games for treatment of ADHD, low self-esteem, and traumatized children.* Pflugerville, TX: Morning Glory Treatment Center for Children.

Levy, D. M. (1938). Release therapy in young children. *Psychiatry, 1*, 387-390.

Levy, D. M. (1939). Release therapy. *American Journal of Orthopsychiatry, 9*, 713-736.

Lewis, M. (1995). Memory and psychoanalysis: A new look at infantile amnesia and transference. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 405-417.

Lohr, J. M., Kleinknecht, R. A., Conley A. T., Del Cerro, S., Schmidt, J., & Sontag, M. E. (1992). A methodological critique of the current status of eye movement desensitization (EMD). *Journal of Behavior and Experimental Psychiatry, 23*, 159-167.

Lovett, J., & Shapiro, F. (1999). *Small wonders: Healing childhood trauma with EMDR*. New York: Free Press.

Madanes, C. (1990). *Sex, love and violence*. New York: Norton.

Main, M., Kaplan, K., & Casidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points in attachment theory and research* (pp. 66-104). Chicago: University of Chicago Press.

Malenbaum, R., & Russell, A. T. (1987). Multiple personality disorder in an eleven-year-old boy and his mother. *Journal of the American Academy of Child & Adolescent Psychiatry, 26*, 436-439.

March, J. (1998). *Manual for the Multidimensional Anxiety Scale for Children*. Toronto: MultiHealth Systems.

March, J., Amaya-Jackson, L., Foa, E., & Treadwell, K. (1999). Trauma focused coping treatment of pediatric post-traumatic stress disorder after single-incident trauma (Version 1.0). Unpublished protocol.

March, J., Amaya-Jackson, L., Murry, M., & Schulte, A. (1998). Cognitive-behavioral psychotherapy for children and adolescents with post-traumatic stress disorder following a single incident stressor. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 585-593.

March, J., Amaya-Jackson, L., Terry, R., & Costanzo, P. (1997). Post-traumatic stress in children and adolescents after an industrial fire. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, 1080-1088.

Metter, J., & Michelson, L. K. (1993). Theoretical, clinical, research, and ethical constraints of the EMDR technique. *Journal of Traumatic Stress*, 6, 413-415.

Nader, K. (1991, February 28). *Posttraumatic stress assessment: East Coldenham Elementary School*. Unpublished report.

Nader, K. (1994). Countertransference in treating trauma and victimization in childhood. In J. P. Wilson & J. Lindy (Eds.), *Countertransference in the treatment of post-traumatic stress disorder* (pp. 179-205). New York: Guilford Press.

Nader, K. (1997a). Assessing traumatic experiences in children. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma & PTSD* (pp. 291-348). New York: Guilford Press.

Nader, K. (1997). Treating traumatic grief in systems. In C. R. Figley, B. E. Bride, & N. Mazza (Eds.), *Death and trauma: The traumatology of grieving* (pp. 159-192). London: Taylor and Francis.

Nader, K. (1998). Violence: Effects of a parents' previous trauma on currently traumatized children. In Y. Danieli (Ed.), *An international handbook of multigenerational legacies of trauma* (pp. 571-583). New York: Plenum Press.

Nader, K. (2001). Treatment methods for childhood trauma. In J. P. Wilson, M. Friedman, & J. Lindy, (Eds.), *Treating psychological trauma and PTSD* (pp. 278-334). New York: Guilford Press.

Nader, K. (in press). Treating children after violence in schools and communities. In N. B. Webb (Ed.), *Helping bereaved children* (2nd ed.). New York: Guilford Press.

Nader, K., Dubrow, N., & Stamm, B. (Eds.) (1999). *Honoring differences: Cultural issues in the treatment of trauma and loss*. Philadelphia: Taylor and Francis.

Nader, K. & Mello, C. (2000). Interactive trauma/grief focused therapy. In P. Lehmann & N. F. Coady (Eds.), *Theoretical perspectives for direct social work practice: A generalist-eclectic approach* (pp. 382-401). New York: Springer Publishing.

Nader, K., & Pynoos, R. (1991). Play and drawing as tools for interviewing traumatized children. In C. Schaeffer, K. Gitlin, & A. Sandgrund (Eds.), *Play, diagnosis and assessment* (pp. 375-389). New York: Wiley.

Nader, K., & Pynoos, R. (1993). School disaster: Planning and initial interventions. *Journal of Social Behavior and Personality, 8*, 299-320.

National School Safety Center. (1999). *School associated violent deaths*. Available Online: www.nssc1.org

Neisser, U. (1976). *Cognition and reality: Principles and implications of cognitive psychology*. San Francisco: Freeman.

Ochberg, F. M., & Soskis, D. A. (1982). Planning for the future: Means and ends. In F. M. Ochberg & D. A. Soskis (Eds.), *Victims of terrorism* (pp. 173-190). Boulder, CO: Westview Press.

Parson, E. R. (1984). The reparation of the self: Clinical and theoretical dimensions in the treatment of Vietnam combat veterans. *Journal of Contemporary Psychotherapy, 14*, 14-56.

Parson, E. R. (1994). Post-traumatic ethnotherapy (P-TET): Processes in assessment and intervention in aspects of global psychic trauma. In M. B. Williams & J. F. Sommer (Eds.), *Handbook of post-traumatic therapy* (pp. 221-239). Westport, CT: Greenwood Press.

Parson, E. R. (1996a). Child trauma therapy and the effects of trauma, loss, dissociation. A multisystems approach to helping children exposed to lethal urban community violence. *Journal of Contemporary Psychotherapy, 26*, 117-162.

Parson, E. R. (1996b). It takes a village to heal a child: Necessary spectrum of expertise and benevolence by therapists, non-governmental organizations, and the United Nations in managing warzone stress in children traumatized by political violence. *Journal of Contemporary Psychotherapy, 26*, 251-286.

Parson, E. R. (1997). Post-traumatic child therapy (P-TCT): Assessment and treatment factors in clinic work with inner-city children exposed to catastrophic community violence. *Journal of Interpersonal Violence, 12*, 172-194.

Parson, R. (2000). *Post-trauma Child Therapy (PTCT) with inner city children and adolescents*. An unpublished paper.

Pellicer, X. (1993). Eye movement desensitization treatment of a child's nightmares: A case report. *Journal of Behavior Therapy and Experimental Psychiatry, 24*, 73-75.

Peterson, G. (1996). Treatment of early onset. In J. L. Spira & I. D. Yalom (Eds.), *Treating dissociative identity disorder* (pp. 135-181). San Francisco: Jossey-Bass.

Puffer, M. K., Greenwald, R., & Elrod, D. E. (1998). A single session EMDR study with twenty traumatized children and adolescents. *Traumatology* 3(2). Available Online: www.fsu.edu/~trauma/v3i2art6.html

Putnam, F. W. (1986). The treatment of multiple personality: State of the art. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 175-198). Washington, DC: American Psychiatric Press.

Putnam, F. W. (1989a). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford Press.

Putnam, F. W. (1989b). Pierre Janet and modern views of dissociation. *Journal of Traumatic Stress, 2*, 413-429.

Pynoos, R.S. (1993). Traumatic stress and developmental psychopathology in children and adolescents. In J. M. Oldham, M. B. Riba, & A. Tasman (Eds.), *American Psychiatric Press review of psychiatry* (Vol. 12, pp. 205-238). Washington, D C: American Psychiatric Press.

Pynoos, R. S., & Eth, S. (1985). Children traumatized by witnessing acts of personal violence: Homicide, rape, or suicide behavior. In S. Eth & R. Pynoos (Eds.), *Post-traumatic stress disorder in children* (pp. 17-43). Washington, D C: American Psychiatric Press.

Pynoos, R. S., & Eth, S. (1986). Witness to violence: The child interview. *The Journal of the American Academy of Child Psychiatry, 25*, 306-319.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Eth, S., Nunez, W., Steinberg, A., & Fairbanks, L. (1987). Life threat and posttraumatic stress in school age children. *Archives of General Psychiatry, 44*, 1057-1063.

Pynoos, R. S., & Nader, K. (1988a). Children who witness the sexual assaults of their mothers. *Journal of the American Academy of Child & Adolescent Psychiatry, 27*, 567-572.

Pynoos, R. & Nader, K. (1988b). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*, 445-473.

Pynoos, R. S., & Nader, K. (1989). Children's memory and proximity to violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*, 236-241.

Pynoos, R., & Nader, K. (1993). Issues in the treatment of post traumatic stress disorder in children and adolescents. In J. Wilson & B. Raphael (Eds.), *The international handbook of traumatic stress syndromes* (pp. 535-539). New York: Plenum Press.

Rossman, B., Bingham, R. D., & Emde, R. N. (1997). Symptomatology and adaptive functioning for children exposed to normative stressors, dog attack, and parental violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 1089-1097.

Schaeffer, C., Gitlin, K., & Sandgrund, A. (Eds.). (1991). *Play, diagnosis and assessment.* New York: Wiley.

Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal, 16*, 259-270.

Sgroi, S. M. (1982). *Handbook of clinical intervention in child sexual abuse.* Lexington, MA: Lexington Books.

Sgroi, S. M. (Ed.). (1988). *Vulnerable populations: evaluation and treatment of sexually abused children and adult survivors.* Lexington, MA: Lexington Books.

Shapiro, F. (1989a). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2*, 199-223.

Shapiro, F. (1989b). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 20*, 211-217.

Shapiro, F. (1991a). Eye movement desensitization and reprocessing procedure: A cautionary note. *The Behavior Therapist, 14*, 188.

Shapiro, F. (1991b). Eye movement desensitization and reprocessing procedure: Basic principles, protocols and procedures. New York: Guilford Press.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.

Shaw, J. (1997). Children of the storm: A study of school children and Hurricane Andrew. In C. S. Fullerton & R. J. Ursano (Eds.), *Posttraumatic stress disorder: acute and long-term responses to trauma and disaster* (pp. 123-143). Washington, DC: American Psychiatric Press.

Siegel, D. J. (1996). Cognition, memory and dissociation. *Child and Adolescent Psychiatric Clinics of North America, 5*, 509-536.

Silberg, J. L. (1998a). Afterword. In J. L. Silberg (Ed.), *The dissociative child: Diagnosis, treatment, and management* (2nd ed., pp. 333-349). Towson, MD: Sidran Press.

Silberg, J. L. (Ed.). (1998b). *The dissociative child: Diagnosis, treatment, and management*. Towson, MD: Sidran Press.

Silberg, J. L. (2001). Treating a young teenage girl with maladaptive dissociation: Case presentation and discussion. In H. Orvaschel, J. Faust, & M. Herson (Eds.), *Handbook of conceptualization and treatment of child psychopathology* (pp.449-474). Oxford, England: Elsevier Science.

Silberg, J. L., & Waters, F. W. (1998). Factors associated with positive therapeutic outcome. In J. Silberg (Ed.), *The dissociative child* (pp. 105-112). Lutherville, MD: Sidran Press.

Solomon, A., Moshe, K., & Mikulincer, M. (1988). Combat-related posttraumatic stress disorder among second-generation Holocaust survivors: Preliminary findings. *American Journal of Psychiatry, 145*, 865-868.

Stamm, B. H. (Ed.). (1996). *Measurement of stress, trauma and adaptation*. Lutherville, MD: Sidran Press.

Suomi, S. J., & Levine, S. (1998). Psychobiology of intergenerational effects of trauma. In Y. Danielli, (Ed), *International handbook of multigenerational legacies of trauma* (pp. 623-637). New York: Plenum Press.

Sweeney, D. S., & Homeyer, L. (Eds.). (1999). *The handbook of group play therapy*. New York: Jossey-Bass.

Terr, L. C. (1983). Play therapy and psychic trauma: A preliminary report. In C. Schaefer & K. O'Connor (Eds.), *Handbook of play therapy* (pp. 308-319). New York: Wiley.

Terr, L. C. (1989). Treating psychic trauma in children: A preliminary discussion. *Journal of Traumatic Stress, 2*, 3-20.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*, 10-20.

Terr, L. C. (1994). *Unchained memories: True stories of traumatic memories, lost and found*. New York: Basic Books.

Terr, L. C. (1999). *Beyond love and work*. New York: Scribner.

Terr, L. C. (2001). Childhood posttraumatic stress disorder. In G. O. Gabbard (Ed.), *Treatment of psychiatric disorders* (3rd ed., Vol. 1) (pp. 293-306). Washington, DC: American Psychiatric Press.

Thompson, R. A. (1991). Attachment theory and research. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 100-108). Baltimore, MD: Williams & Wilkins.

Touch Research Institute. (1999). Touch deprivation: The stigma of touch. *Touch Research Abstracts*, 5. Available Online: www.miami.edu/touch-research/index.html

Trepper, T. S., & Barrett, M. J. (1986). Vulnerability to incest: A framework for assessment. In T. S. Trepper & M .J. Barrett (Eds.), *Treating incest: A multiple systems perspective* (pp. 13-25). New York: Haworth Press.

Trepper, T. S., & Barrett, M. J. (1989). *Systemic treating of incest: A therapeutic handbook*. New York: Brunner/Mazel.

van der Kolk, B., & Sapporta, J. (1991). The biological response to psychic trauma: Mechanisms and treatment of intrusion and numbing. *Anxiety Research*, 4, 199-212.

Webb, N. B. (1991). *Play therapy with children in crisis, a casebook for practitioners*. New York: Guilford Press.

Webb, N. B. (1999). *Play therapy with children in crisis, individual, group and family treatment* (2nd ed.). New York: Guilford Press.

Williams, M. B. (1994). Intervention with child victims of trauma in the school setting. In M. B. Williams & J. F. Sommer (Eds.), *Handbook of post-traumatic therapy* (pp. 69-77). Westport, CT: Greenwood Press.

Yule, W., & Williams, R. M. (1990). Post-traumatic stress reactions in children. *Journal of Traumatic Stress*, 3, 279-295.

Endnotes

[1] Drawings and play may be used as assessment measures as well (Nader & Pynoos, 1991; Schaeffer, Gitlin, & Sandgrund, 1991).

[2] A specific Jungian version rather than simply play in a sand tray (Kalff, 1980).

[3] See Silberg's method (Silberg, 1998a) in the section on Treatment for Dissociative Disorders elsewhere in this chapter.

Section

6

Special Issues in Crisis Prevention and Response

We conclude this volume by offering several chapters that address special issues in school crisis prevention and intervention. The section begins with a discussion of legal and ethical issues relevant to this topic (Chapter 34 by Susan Jacob and Ted Feinberg). This chapter includes discussion of the legal aspects of schoolwide efforts to prevent student violence, as well as legal and ethical aspects of the mental health practitioner's role in violence intervention and response.

Next, we offer a review of strategies designed to advocate for school crisis prevention and intervention (Chapter 35 by Libby Kuffner Nealis). This chapter begins by examining what policies exist, or have been proposed, regarding crisis intervention in schools and communities. It then explores the need for continued advocacy efforts. The chapter concludes with a discussion of how individuals can advocate for crisis prevention and intervention at the local, state, and federal levels.

Finally, the book ends with two important chapters dealing with future research needs (Chapter 36 by Michael Bates, Michael Furlong, Jill Saxton, and Renee Pavelski and Chapter 37 by Pauline Pagliocca, Amanda Nickerson, and Stephanie Williams). As was mentioned in the introduction to the first section of this book, while there is much that we do know about school crisis prevention and intervention, there is even more that we have yet to learn. This is particularly true in the area of school crisis intervention, where virtually no research has been conducted, and most of what we do know comes from study in related fields. Given these facts, it is absolutely critical that continued research be conducted. It is our most sincere hope that 5 to 10 years from now, a second edition of this volume will be required because much new knowledge will have been learned about school crisis prevention and intervention. To a significant degree, we will consider this book a success if it helps to stimulate further research regarding best practices in school crisis prevention and intervention.

34

危機

Legal and Ethical Issues in Crisis Prevention and Response in Schools[1]

Susan Jacob, Ph.D.
Central Michigan University

Ted Feinberg, Ph.D.
National Association of School Psychologists

This chapter focuses on the legal and ethical issues associated with school efforts to prevent violent student behaviors, as well as issues associated with crisis response. Part I of the chapter focuses on legal aspects of schoolwide efforts to prevent student violence. Part II addresses legal and ethical aspects of the mental health practitioner's role in violence intervention and response.

Part I: Legal Aspects of Student Violence Prevention

School administrators are responsible for development and implementation of school policies along with day-to-day management of the operation of schools. In light of recent incidents of school violence, school psychologists and other mental health professionals have been called on to work with administrators and others to develop safe school and crisis response plans. Consequently, mental health practitioners need a sound working knowledge of the legal and ethical issues related to violence prevention and response in schools. This knowledge will help psychologists and others ensure that efforts to promote a safer school environment do not violate the legal rights of pupils and their parents and that policies are planned and implemented in ways that are respectful of the dignity of individual students.

The following sections discuss the legal authority and duty of the school to ensure an orderly and safe school environment, summarize federal legislation to promote safe and violence-free schools, and address legal issues associated with specific school practices to create safer schools.

Legal Authority to Ensure Safe Schools

The U.S. Constitution does not specifically refer to "education" as a duty of the federal government. The duty to educate children and the power to do so have been left to the states. Most states delegate much of the authority for the management of public schools to local school boards. Public schools are consequently considered to be an arm of state government, and actions by the school board or school staff in their official roles are viewed as actions by the state.

The original Constitution outlined the duties and powers of the federal government. The Bill of Rights was passed to ensure a clearer balance of power between the federal government and the states, and to safeguard the rights of individual citizens. The 14th Amendment was created to prevent state governments from trespassing on the rights of individual citizens: "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the law." The right to a public education given by state law is considered to be a property right. The equal protection clause of the 14th Amendment has been interpreted by the courts to mean that a state has a duty to provide equal educational opportunities to all children within the state regardless of race, color, national origin, native language, sex, and disability. There are two aspects of the due process clause: substantive and procedural. In accordance with court interpretations of substantive due process, a state may not pass a law that deprives citizens of life, liberty, or property if the law is not related to a legitimate governmental purpose; arbitrary and capricious laws that impact on citizen rights will be ruled unconstitutional. This part of the 14th Amendment has been interpreted to mean that school rules restricting student rights must be reasonably related to the purpose of schooling. Procedural due process means that a state may not take away life, a liberty interest, or a property right without some sort of procedural fairness to safeguard citizens from wrongful infringement of rights by the government. Procedural due process has been interpreted to mean that schools may not suspend or expel students from school without some sort of fair, impartial due process procedures, including notice of what the school proposes to do and why, and the opportunity to be heard.

The courts have recognized that the formulation and enforcement of school rules is necessary for the maintenance of an orderly learning environment. Under the general mandate to operate a public school, school officials have been given "a wide latitude of discretion" to ensure that the educational purposes of the school are carried out (Burnside v. Byars, 1966, p. 748; Sales, Krauss, Sacken, & Overcast, 1999). As noted above, however, school rules and regulations must be a reasonable exercise of the power and discretion of school authorities, related to the purpose of maintaining order and discipline (Burnside v. Byars, 1966), and enforced in a nondiscriminatory manner.

The closer a school policy, rule, or action comes to an abridgment of constitutional rights, the greater the need for justification by school officials (Reutter, 1994). In

Tinker v. Des Moines Independent Community School District (1969), the U.S. Supreme Court recognized the need to balance the school's interest in maintaining discipline with the fundamental personal freedoms guaranteed citizens in the Bill of Rights. Tinker concerned three students who were suspended from school for violating a school policy prohibiting pupils from wearing black armbands in protest of the war in Vietnam. In the Court's view, the school's policy banning armbands was seen as an unreasonable violation of the students' constitutional right to freedom of expression because there was no evidence that the silent wearing of armbands interfered with or disrupted the functioning of the school. Thus, although children in the school setting are not afforded the full range of personal freedoms guaranteed citizens by the Bill of Rights, they nevertheless do maintain certain fundamental rights in the school setting. In developing and implementing school policies, schools must consider the constitutional rights of pupils, including the right to freedom of speech, expression, and assembly and the right to be free from unreasonable search and seizure.

The courts have also generally held that school rules should be clearly stated and the consequences for conduct code violations should be reasonably explicit. Students should be informed of expectations for appropriate conduct through written statements or instruction (Reutter, 1994). The courts have not required, however, that every school regulation be formally adopted and publicized by school authorities before it can be enforced. Courts have also held that the enforcement of school rules and regulations should be fair and reasonable, "giving due regard to all the circumstances surrounding the nature of each event and the age, health, and mental condition of the student" (Sales et al., 1999, p. 1121).

Duty to Ensure Safe Schools

Generally, under state statutory law and common law, school personnel have a duty to ensure the safety of pupils under their supervision (Schill, 1993). California specifically recognizes the right of students to safe and peaceful schools in its state constitution (Rapp, Carrington, & Nicholson, 1992). In addition, school employment contracts often contain a provision whereby any act or failure to act that jeopardizes pupil health, safety, or welfare can result in suspension or termination of employment. Thus, school personnel generally have a legal as well as a moral obligation to take steps to ensure the safety of students under their supervision.

Legislation to Promote Safe and Violence-Free Schools

Although school safety is primarily a state matter, the federal government has passed legislation to foster safe and violence-free schools. Some of this federal legislation is grant legislation, that is, funds are provided to states on the condition that schools comply with certain educational policies and practices. The Goals 2000: Educate America Act, which was passed in 1994, promotes school improvements consistent with eight national education reform goals. Goal Seven is "Safe, disciplined, and alcohol- and drug-free schools." This part of the legislation makes funds available for high-crime schools to develop violence-prevention materials and implement violence-reduction programs (see 20 U.S.C. § 5965).

The Improving America's Schools Act (IASA) is a set of 1994 amendments to the Elementary and Secondary Education Act of 1965 (ESEA). Subchapter IV of IASA, "Safe and Drug-Free Schools and Communities," provides federal assistance to states for coordination and development of efforts to prevent violence and reduce illegal drug use in the schools (see 20 U.S.C.S. § 7103). The General Provisions section of IASA (subchapter XIV) also includes "The Gun-Free Schools Act of 1994." This portion of the legislation requires each state receiving federal funds under ESEA to have in effect a state law requiring schools to expel for a period of not less than one year a student who brings a weapon to school. However, the law must allow the chief school administrator to modify the expulsion requirement on a case-by-case basis, and states may allow students expelled from their regular school to receive educational services in an alternative setting. The Act also requires that incidents of students bringing weapons to school be reported to the juvenile or criminal justice system (see 20 U.S.C.S. § 8921).

In addition to federal grant legislation, federal antidiscrimination law protects students from harassment and hate crimes based on race, color, national origin, sex, and disability. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin in programs or activities receiving federal financial assistance and makes schools responsible for taking reasonable steps to remedy racial harassment of students. Similarly, Title IX of the Education Amendments of 1972 prohibits discrimination on the basis of gender and makes schools responsible for taking reasonable steps to remedy sexual harassment of students. Section 504 and the Rehabilitation Act of 1964 and Title II of the Americans with Disabilities Act of 1990 prohibit discrimination based on disability. Federal statutory law does not currently protect public school students from discrimination or harassment based on sexual orientation; however, harassment on the basis of sexual orientation may violate state laws or the U.S. Constitution (see Nabozny v. Podlesny, 1996).

Because education is primarily a state matter, school practitioners need to be familiar with the laws of the state in which they practice as well as with local district policies. In addition, school professionals such as psychologists, counselors, and social workers need to be familiar with law that impacts mental health practitioners in their state.

Legal Issues Associated With Violence-Reduction Practices

Efforts to create violence-free school environments have included the development of safe school plans and crisis response teams. Specific components of safe school plans vary, and most components raise few legal-ethical concerns (see Section II, Primary Prevention: Preventing and Preparing for Crisis Events, this volume, for a discussion of the elements of safe school plans). However, increases in campus security, increased

705

information-sharing about students who commit violent acts, changes in school disciplinary policies, and schoolwide programs to identify students at risk for violent behaviors pose special legal concerns.

Increased Campus Security

Search and seizure. The Fourth Amendment states that "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but on probable cause ..." Courts have interpreted this amendment to protect an individual's reasonable expectations of privacy and to protect against arbitrary invasions by government officials. In light of increased concerns about weapons and drugs on school grounds, school officials and the courts have wrestled with the question of how to balance the state's (school's) interest in maintaining a safe learning environment with the students' constitutionally protected interest in privacy (Ferraraccio, 1999).

To understand the scope of constitutionally permissible searches in the school setting, it is important to distinguish search of an individual student on the basis of suspicion from blanket (nonindividualized) searches to protect safety. The most important court decision regarding individualized search was New Jersey v. T.L.O. (1985), a case that concerned whether school officials had the right to search a student's purse. The U.S. Supreme Court engaged in a two-part inquiry to determine the legality of the search, namely, "Was the search justified at its inception?" and "Was the search, as actually conducted, reasonably related in scope to the circumstances which justified the search in the first place?" While holding that students have a legitimate expectation of privacy rights with regard to their person and possessions in school, the Court in T.L.O. upheld the standard of *reasonable suspicion* as opposed to *probable cause* for conducting individual searches, thus giving more latitude in the case of students than provided adults by the Fourth Amendment. School officials must, however, have reasonable grounds to suspect a search will produce evidence that the student violated school rules or committed a crime; the search must be justified at its inception by more than a rumor or hunch.

The Court also noted that search must not be "excessively intrusive in light of the age and gender of the pupil and the nature of the infraction" (New Jersey v. T.L.O., 1985, p. 342). The more personal the search (i.e., the closer the search comes to the body), the more serious the reasons the school must have for conducting the search. Thus, a search of a student's body for a weapon would more likely be viewed as legally permissible than an intrusive search for missing money. In our opinion, strip searches of children should be avoided (if at all possible) because they may result in emotional distress, anger, and alienation (Hyman & Perone, 1998).

The courts have more recently addressed the issue of search in the absence of individualized suspicion in public schools. Courts have ruled that nonindividualized or blanket search may be permissible when conducted in pursuit of the protection of student and staff safety. In cases where the individualized suspicion is absent, however, the court will again examine whether the search was justified at its inception and the procedure used in conducting the search. Blanket searches must be justified by state (school) interests compelling enough to override students' privacy interests (e.g., documented history of weapons incidents at school); Individual students should not be singled out for search unless there is reasonable suspicion that the individual has the object that is the target of the search (Ferraraccio, 1999).

Whether a search is considered permissible also depends on the courts' determination regarding when a legitimate expectation of privacy is present. Different courts have had differing opinions whether students have a legitimate expectation of privacy with regard to their lockers, cars, and, in the case of canine searches, the airspace surrounding their body, locker, or car (Ferraraccio, 1999). Several state courts have addressed the issue of school locker searches. In Commonwealth v. Snyder (1992), the court stated that students have a reasonable expectation of privacy in regard to their lockers, but only if there is no "express understanding to the contrary" (p. 1366). If schools adopt a policy informing students that their lockers are not private, school locker searches are likely to be viewed as permissible (In Interest of Isaiah B., 1993).

A number of state and federal courts (e.g., People v. Dukes, 1992; Thompson v. Carthage School District, 1996) have held that the use of metal detectors to scan for weapons in a public school is constitutionally permissible if justified by documented concerns about school safety. Students should be given prior notice that metal detector searches will take place, and procedures must be fair, that is, either all students who enter the school should be subjected to search, or the search should limited by a random selection process.

Police on campus. In response to increased concerns about school safety, many districts have hired security professionals or have police on campus. Commissioned police officers can make arrests. However, as Lawrence (1998) noted, police have considerable discretionary power in handling juvenile matters, particularly minor offenses, and, along with input from school personnel, may use judgment in deciding whether a situation is best handled through educating, reprimanding and warning, referral to a community agency, or arrest. In our opinion, when a school has police on campus, there needs to be clear understanding of their roles, and this information should be communicated to students, staff, and families. Campus police can be part of a positive school climate that emphasizes education and rehabilitation to prevent violence, or their presence could contribute to a punitive climate that fosters student alienation and mistrust.

Improved Information-Sharing About Students Who Commit Violent Acts

Many school safety experts have called for improved coordination between schools and the judicial system (Pitcher & Poland, 1992). Troubled students are often placed back in the public schools by the justice system as a condition of court-ordered supervision. Unfortunately, "the school phase of probation unfolds without any realistic hope of proper supervision, because school officials are not informed of the presence of the juvenile on probation" (James, 1997, p. 461). If schools are to play a positive role in assisting troubled youths, schools must be notified when students are on parole and probation, informed about the nature of the offense and the scope of the probation, and provided the names of the probation officers or social workers assigned to work with those students and how to contact them to exchange information to assist the student (James, 1997; Pitcher & Poland, 1992). State laws govern the disclosure of juvenile justice system information to schools. James (1997) identified 24 states that authorize sharing of juvenile record information on a routine basis among agencies in the state. In other states, schools need to develop agreements with juvenile justice agencies to foster easier access to the juvenile justice records of students and need to better coordinate efforts to assist troubled youths (Pitcher & Poland, 1992).

Although schools could better assist adjudicated youths if they had more information from the juvenile justice system, the converse is also true; the juvenile justice system could better intervene with troubled youths if schools would consistently report criminal acts by students at school to law enforcement agencies (Pitcher & Poland, 1992). Citing information gathered by the American Association of School Administrators, Rapp et al. (1992) reported that school administrators are reluctant to report crimes by students to law enforcement, often because they wish to avoid involvement in litigation and negative publicity for the school. Failure to report a criminal act by a student, however, may make it difficult to secure needed help from the juvenile justice system when the student commits a second offense because law enforcement has no record of a prior criminal act. The Gun-Free Schools Act requires schools to report to law enforcement incidents of students bringing weapons to school. Also consistent with the call for improved information-sharing between schools and law enforcement, the 1997 amendments to the Individuals with Disabilities Education Act (IDEA) specifically state that school personnel may report a crime committed by a child with a disability to appropriate authorities. Nothing in the law prevents law enforcement authorities from exercising their duties with regard to crimes committed by a child with a disability.

Additionally, as James (1997) has observed, there are currently many misconceptions among school personnel regarding the meaning of the Family Educational Rights and Privacy Act of 1974 (FERPA) as it relates to sharing information about crimes committed at school with the juvenile justice system. FERPA record-keeping guidelines were developed to ensure confidentiality of pupil education records and parent access to school records concerning their children. Pupil *education records* are to be available only to those in the school setting with a legitimate educational interest, and parent consent must be obtained before education records are released to agencies or individuals outside of the school. *School law enforcement unit records*, however, do not fall within the meaning of education record as defined by FERPA. Law enforcement records are records maintained by a law enforcement unit of the school, created by that unit for the purpose of law enforcement. Law enforcement unit means any department, section, or individual in the school authorized to enforce the law or to refer violations to appropriate authorities, and may be a school staff member if the school does not have a safety unit. School law enforcement records thus include information regarding student violations of federal, state, or local law, and such records may be disclosed to other law enforcement agencies (e.g., juvenile justice officials) without prior consent (James, 1997).

In the past, confusion about the meaning of FERPA also prevented educators from sharing information with each other about violent students. Prior parent consent is *not* needed to share education record information concerning disciplinary actions taken against a student with teachers and school officials, including teachers and officials in other schools who have legitimate educational interests in the behavior of the student. It also is important to remember that FERPA allows disclosure of education record information without consent in response to an emergency (James, 1997).

Discipline

Suspension and expulsion. Schools have been given the authority to suspend or expel students to maintain order and carry out the purposes of education. The grounds for disciplinary suspensions and expulsions vary from state to state. In accordance with the Gun-Free Schools Act, states receiving ESEA funds must have a law requiring schools to expel for not less than one year students who have brought a weapon to school, although the school's chief administrator may make exceptions to the expulsion requirement on a case-by-case basis. Schools may provide education to expelled students in an alternative setting. School codes also are likely to allow suspension or expulsion of students guilty of persistent noncompliance with school rules and directives, stealing or vandalizing property on school grounds, and using violence or encouraging the use of violence (Reutter, 1994). School conduct codes should be as explicit as possible in identifying infractions that will result in suspension or expulsion.

In 1975, the U.S. Supreme Court decided Goss v. Lopez, a case filed on behalf of several high school students suspended without any sort of informal due process hearing. The Court ruled that because education is a state-created property right, the school may not suspend or expel pupils without some sort of due process procedures to protect students from arbitrary or wrongful infringement of their interest in schooling. In writing the majority opinion, Justice White outlined the minimal due process procedures required for suspensions of 10 days or less:

> … the student [must] be given oral or written notice of the charges against him and, if he denies them, an explanation of the evidence the authorities have and an opportunity to present his side of the story (Goss v. Lopez, 1975, p. 740).

Justice White further noted, "longer suspensions or expulsions for the remainder of the school term, or permanently, may require more formal procedures" (Goss v. Lopez, 1975, p. 741). He also noted that, generally, the notice and hearing should precede the removal of the pupil from the school. However, pupils "whose presence poses a continuing danger to persons or property or an ongoing threat of disrupting the academic process may be immediately removed from school. In such cases, the necessary notice and rudimentary hearing should follow as soon as practicable" (Goss v. Lopez, 1975, p. 740).

IDEA includes a number of special rules regarding suspension or expulsion of students with disabilities.[3] With regard to short-term suspension, school personnel may unilaterally place a child with a disability in an appropriate interim alternative educational setting (IAES), another setting, or suspension, for up to 10 school days at a time for a violation of school rules, as long as there is not a pattern suggesting inappropriate multiple removals.

School personnel may order a longer change of placement (up to 45 days) to an IAES to address disciplinary infractions concerning weapons or drugs. In addition, a hearing officer may order a child with a disability be placed in an IAES for not more than 45 days if the officer determines that the school has demonstrated that maintaining the current placement of the child is substantially likely to result in injury to the child or to others in spite of reasonable efforts to minimize the risk of harm in the child's current placement.

When a child with a disability is first removed for more than 10 days in a school year, and whenever a child is subjected to a disciplinary change of placement of more than 10 consecutive school days, the school must convene an Individualized Education Program (IEP) team meeting. If the child had a behavioral intervention plan prior to the disciplinary action, the IEP team is required to review the plan and modify it as necessary to address the problem behavior. If no behavioral plan existed prior to the disciplinary action, an IEP team is required to develop and implement a behavioral intervention plan to address the behavior that resulted in the disciplinary action.

When disciplinary action involves a change of placement (removal for more than 10 consecutive school days), a *manifest determination* review must be conducted. This review examines the relationship between the child's disability and the behavior that resulted in the disciplinary action. If the result of the review is a determination that the behavior that led to the disciplinary action was not a manifestation of the child's disability, the relevant disciplinary procedures applicable to children without disabilities (i.e., long-term suspension or expulsion) may be applied to the child in the same manner as would be applied to children without disabilities, except that children with disabilities must continue to receive special education services.

In our opinion, suspension and expulsion are not likely to be an effective means of reducing aggressive behaviors among youths. If schools hope to reduce youth violence, all students who display aggressive and antisocial behaviors should receive appropriate assistance (e.g., adult mentoring, remedial instruction, counseling, and behavioral interventions).

Regulation of speech and dress. Consistent with federal antidiscrimination legislation and ethical principles regarding nondiscrimination, safe school plans should include policies to ensure that students and staff are free from verbal abuse and intimidation based on race, color, national origin, sex, disability, and sexual orientation. Such harassment can lead to violence [U.S. Department of Education (DOEd) & Bias Crimes Task Force of the National Association of Attorneys General, 1999]. In developing and applying policies to prevent harassment, however, schools must consider student First Amendment rights to free speech and expression. Demeaning or abusive verbal or written statements of a sexual or racial nature, or derogatory statements based on religion, national origin, disability, or sexual orientation, are likely to be viewed as harassment, particularly if there is intent to discriminate against or intimidate others and a pattern of harassing statements. Similarly, graffiti or visual displays that are demeaning of others on the basis of race, color, national origin, sex, disability, or sexual orientation may constitute harassment. Whether a statement or visual display constitutes harassment, or is free speech and expression protected by the First Amendment, depends on the facts and context involved, including the type and timing of the speech or expression; the nature of the forum in which it takes place; and the educational level and age of the students involved (DOEd, 1999). The same language and symbols used to harass and intimidate others (e.g., racial slurs, image of a burning cross) may appear in student poems, plays, stories, artwork, or other creative expression and still fall within the scope of protected speech. (See DOEd, 1999, for a guide for schools in developing appropriate policies.)

Similarly, in the development and enforcement of other types of school rules regulating student speech and expression, schools must make distinctions between speech that is disruptive to school functioning, and therefore not protected by a student's First Amendment rights (e.g., threats of school violence), and speech that is unpopular but protected, such as speech critical of teachers or the school administration (Beussink v. Woodland R-IV School District, 1998; Tinker v. Des Moines Independent Community School District, 1969). In addition, students may write or talk about school violence as a means of healthy coping with their fears and feelings. Although violent themes in a pupil's creative work may signal a need for assessment of the student by a mental health professional, the recent arrests of students for "violent threats" based on English class compositions raise First Amendment concerns (Simpson, 2000).

A number of districts have adopted a school dress code that prohibits students from wearing gang-related apparel. Some districts require a school uniform (e.g., white shirt, dark pants or skirt) as a means of fostering school pride, reducing clothing theft, and protecting pupils from gangs (Alvarez, 1995). A number of court cases have addressed the issue of whether, and under what circumstances, school regulation of aspects of student dress violates a child's First Amendment right to free expression. In Olesen v. Board of Education (1987), a federal court upheld a ban on gang-associated jewelry in an Illinois School District. To date, there have been few court rulings on school uniform policies. In general, legal experts believe school uniform policies are likely to be permissible if the policy is created as a means of fostering school safety, it allows parents the right to elect not to send their children to school in a uniform, parents are given adequate notice (at least 6 months) prior to adoption of the policy, and there are provisions for financially disadvantaged students (Alvarez, 1995).

Early Identification and Intervention With Pupils At Risk for Violence

Prompted by the recent history of violent acts in schools, a number of organizations have published lists of characteristics common among students prone to violence (e.g., American Psychological Association, 1999; Dwyer, Osher, & Warger, 1998; National School Safety Center, 1999). In a growing number of districts, these lists or guides serve as the basis for schoolwide efforts to identify pupils at risk for violent acts ("School Psychologists," 1999). Information about the early warning signs that relate to troubling behaviors can be used to educate staff, students, and parents about what to look for so that pupils in need of assistance can receive help early, before their problems become severe (Dwyer et al., 1998). Some districts have implemented "student profiling" programs, however, that raise legal and ethical concerns. Key concerns are inappropriate labeling and stigmatization, invasion of pupil and family privacy without informed consent, and misuse of results.

The due process clause of the 14th Amendment protects individuals from arbitrary or unwarranted stigmatization by the state that may interfere with liberty or property interests. In some districts, unvalidated checklists have been used to identify pupils as "dangerous or potentially dangerous" ("School Psychologists," 1999). School districts that label pupils "potentially violent" on the basis of a screening instrument are violating a pupil's constitutional right to be free from arbitrary stigmatization by the state. Furthermore, many years ago the courts ruled that a school may not assign a potentially stigmatizing label to a child (e.g., "mentally retarded") without due process, some sort of fair decision-making procedure that includes parental notice of the proposed classification, and a right to an impartial hearing to protect against misclassification (Bersoff & Ysseldyke, 1977). Thus, schools should not label students as potentially violent without an opportunity for the parent to participate in that classification decision. In our opinion, when students are identified as "at risk" on the basis of early warning signs, ethically and legally the most appropriate course of action is to inform parents that their son or daughter may need further evaluation by a qualified professional. (For a discussion of assessment of risk for targeted violence, see the section on Threats to Others later in this chapter.) In their attempts to identify troubled youths, schools also are cautioned against asking students to complete surveys or questionnaire that are intrusive of personal or family privacy without written informed parent consent (Bradley, 1998; Merriken v. Cressman, 1973).

Screening results also may be misused in planning interventions. According to one (hopefully erroneous) news report, a midwestern school district used student-profiling results as the basis for placement of students in an alternative education program or expulsion ("School Psychologists," 1999). Interventions with youths at risk for violence should be planned by professionals with expertise in working with troubled youths. In our opinion, removal of students from their regular education environment or denying school access on the basis of profiling results would likely be viewed as impermissible in a court of law.

Part II: Legal and Ethical Aspects of the Mental Health Practitioner's Role in Violence Intervention and Response

This portion of the chapter explores legal and ethical issues in the delivery of psychological or other mental health services to pupils at risk for violent behaviors. It addresses the issues of confidentiality and informed consent, along with specific legal and ethical issues related to services to students at risk for violent acts.

Confidentiality

School psychologists and other mental health professionals are ethically obligated to "respect the confidentiality of information obtained during their professional work. Information is revealed only with the informed consent of the client, or the client's parent or legal guardian, except in those situations in which failure to release information would result in clear danger to the client or others" (PPE, III, A, #9).[4]

Psychologists and other mental health practitioners are ethically obligated to define the parameters of confidentiality at the onset of offering services (PPE, A, #11; also EP, 5.01). When students are seen for counseling or assessment, the initial interview with the student/client "should include a direct and candid discussion of the limits that may exist with respect to any confidences communicated in the relationship" (Koocher & Keith-Spiegel, 1998, p. 117; also EP 5.01; PPE, III, A, #11). There are three situations in which the school mental health practitioner is obligated to share confidential student-client disclosures with others: (1) when the student requests it, (2) when there is a situation involving danger to the student or others (e.g., potential suicide, a student who is danger to others, suspected child abuse or neglect), and (3) when there is a legal obligation to testify in a court of law (Hummel, Talbutt, & Alexander, 1985).

Much has been written about the importance of the promise of confidentiality for building and maintaining the trust essential to a helping relationship (Siegel, 1979). For a troubled student, however, candor about the limits of confidentiality may be more important in fostering trust in adult helpers than a promise of absolute confidentiality that is later broken (Pitcher & Poland, 1992). Taylor and Adelman (1989) provide suggestions regarding how to create an atmosphere of safety and trust in which the pupil knows and understands the exceptions to the promise of confidentiality, yet is motivated to disclose personal thoughts, feelings, and important information.

As Poland (1989) has noted, the ideal situation is for mental health professionals to discuss the limits of confidentiality at the onset of services. At times, however, students are referred for assessment of whether they are a threat to self or others, or self-refer because they are in immediate need of assistance. In such situations, Poland suggests gathering the most complete information possible about the student's thoughts and plans first, and then dealing with the issue of the limits of confidentiality. If students offer to disclose personal matters "on the condition that the counselor promises not to tell anyone," the practitioner should not enter into such an agreement, because the student is likely to feel betrayed when the promise cannot be kept.

When a student is a danger to self or others and it is necessary to disclose information learned in a professional relationship to others, only information "essential to the understanding and resolution" of the student's difficulties is disclosed (Davis & Sandoval, 1982, p. 548; also PPE, II, A, #10). Furthermore, information is shared only with persons clearly concerned with the situation (EP 5.03). Thus, confidential information is disclosed only on a "need-to-know" basis. The individuals who need to be informed about a student who is potentially dangerous to self or others are identified below in the discussions of Threats to Others and Threats to Self. When it becomes apparent that confidentiality must be broken, the decision to divulge information should be discussed with the student-client if possible (see Taylor & Adelman, 1989). In their work with troubled youths, Pitcher and Poland (1992) have found that, if handled with sensitivity, most students come to understand that a decision to disclose confidential information to others is based on the need to help the student or protect others.

Informed Consent

Analyses of federal statutory law (e.g., the Protection of Pupil Rights Amendment of 1994 and IDEA) suggest "clear Congressional intent to require parental consent to school-based psychological services" (Corrao & Melton, 1988, p. 381). School psychologists also have an ethical obligation to seek "direct parent contact" prior to seeing the student/client for assessment or for counseling on an ongoing basis (PPE, III, A, #4; B, #2; C, #1). However, in our opinion, it is ethically permissible to provide psychological services to students without parental consent if such services are necessary to ensure pupil safety. Some states have laws specifically granting minors access to psychological treatment without parental consent under certain conditions such as suicide prevention (Corrao & Melton, 1988; Poland, 1989). School counselors are viewed differently in law than school psychologists, and typically may meet with pupils without parental notice or consent. School districts are well-advised to adopt written policies stating that students may be seen by the school psychologist or other school mental health professional for at least one session without parental notice or consent to ensure the pupil is not in danger from others and to ensure the pupil is not a danger to self or others.

Threats to Others

As noted previously, under state statutory law and case law, school personnel generally have a legal obligation to take steps to ensure the safety of pupils under school supervision. In addition, in many states, therapists have a legal duty to take reasonable steps to prevent anticipated harm when their client is a danger to others (e.g., Tarasoff v. Regents of California, 1976). The assessment of whether or not a student poses a danger to others is not an easy task. School personnel may become concerned about a student because of his or her aggressive, antisocial behavior (e.g., fighting, explosive temper). For such students, the task is to determine the risk for future violent acts and how to reduce the likelihood of future violence. Borum (2000) has provided guidelines regarding how to conduct a systematic assessment of violence potential in such situations. His approach takes into account the student's past violent acts, the precipitants to those acts, and the protective factors, that is, factors that would help the youths avoid potentially violent situations.

Students also may come to the attention of school personnel because they make direct or indirect threats to injure others. The term "targeted violence" is used to refer to situations in which both the potential perpetrator and target(s) are identifiable prior to a violent attack (Vossekuil, Reddy, Fein, Borum, & Modzeleski, 2000). As Borum (2000) notes, a different assessment approach is recommended in situations involving targeted violence.

When students make threats to injure others, such threats should be taken seriously (Reddy, Borum, Vossekuil, Fein, Berglund, & Modzeleski, 2001; Mirand v. Board of Education of the City of New York, 1994). A report sponsored by The Federal Bureau of Investigation recommends a multidisciplinary team approach to threat assessment (FBI Academy, 2000). This team might include mental health professionals, school administrators, and law enforcement professionals. In Milligan et al. v. City of Slidell (2000) a federal court considered whether it is unconstitutional for school officials and police to detain and question students thought to be planning an act of violence at school. In the opinion of the court, the school's interest in deterring school violence outweighs a student's limited Fourth Amendment privacy rights, and therefore it is permissible for school officials and police to summon and question students at school in the interest of preventing school violence.

As Reddy et al. (2001) note, the risk factors for targeted violence do not appear to be the same as the risk factors associated with general aggression and violence recidivism among youths. Based on their study of school shooters, Vossekuil et al. (2000) concluded that the "use of profiles is not effective either for identifying students who may pose a risk for targeted violence at school or—once a student has been identified—for assessing the risk that a particular student may pose for school-based targeted violence" (p. 9).

Reddy et al. (2001) have outlined a model for evaluating whether a student poses a risk for targeted violence that is based on an approach developed by the U.S. Secret Service. Their model is based on three principles: (a) targeted violence is a result of an interaction among the student, situation, target, and setting; there is no single "type" of student prone to such acts; (b) evaluators must make a distinction between a student who makes threats vs. poses a threat; and (c) targeted violence is often the product of an understandable pattern of thinking and behavior. The model involves evaluating the student's behavior and pattern of conduct using information from multiple sources to determine whether the student is "on a pathway toward violent action." Information-gathering might involve interviewing the student, his or her family, teachers, and possibly friends and gathering information from records. Key questions that guide the threat assessment include:

- What motivated the student to make statements or take action, that caused him or her to be a concern to the school?
- Does the student have ideas about or plans for targeted violence?
- Has the student shown an interest in violence, acts of violence by others, or weapons?
- Has the student engaged in any attack-related behavior, including menacing, harassing, or stalking?
- Does the student have a history of substance abuse or psychotic symptoms?
- Is the student cognitively and physically capable of carrying out a plan of violence?
- Has the student experienced a recent loss or loss of status, and has this led to feelings of desperation and despair?
- Is there concern among those who know the student that he/she might take action based on inappropriate ideas?
- What factors in the student's life and/or environment might increase or decrease the likelihood of the student becoming violent? (Reddy et al., 2001; also see Borum, Fein, Vossekuil, & Berglund, 1999).

Consistent with the guidelines for other situations involving danger, schools need to develop written procedures regarding when and how to notify school officials and legal authorities (e.g., police, the student's probation officer) if school staff become aware of a potentially assaultive student. These procedures should ensure that the intended victim is warned. If a student poses a threat to a minor child, the parents of the threatened child should be notified. Parents of a potentially assaultive student should be informed of the situation (see, for example, Phillis P. v. Claremont Unified School District, 1986; also Pitcher & Poland, 1992). The potentially violent student should be supervised in the school setting and at home, and steps should be taken to ensure there is no access to weapons. Mental health practitioners should be prepared to refer the family to a community mental health agency and should be familiar with the procedures for voluntary or involuntary commitment of minors and adult students. Psychology practitioners should know and follow school policies regarding dangerous students and should document their actions in the management of a student who may become violent (Pitcher & Poland, 1992).

Practitioners also need to consider the long-range needs of students at risk for violence with regard to follow-up educational and mental health services. They need to ensure that the student receives well-coordinated assistance from the family, school, and community mental health professionals. Some students may qualify for special educational services within the disability category of emotionally disturbed.

Threats to Self

In Eisel v. Board of Education of Montgomery County (1991), a 13-year-old, "Nina," became involved in satanism and developed an obsessive interest in death. She told several friends that she intended to kill herself. Nina's friends reported her suicidal intentions to their school counselor (at a different school) who conveyed the information to Nina's school counselor. Both counselors met with Nina and questioned her about her statements concerning suicide, but she denied making them. Neither counselor informed Nina's parents or other members of the school staff about her suicidal statements. One week after telling her friends about her suicidal intentions, Nina and another 13-year-old girl consummated a murder-suicide pact.

Nina's father filed a negligence suit against the two school counselors, based on their failure to communicate to him information concerning Nina's contemplated suicide. Nina's father believed he could have prevented his daughter's death had he been told about her suicidal statements. The court held that a school has a special duty to protect a pupil from harm, and that "school counselors have a duty to use reasonable means to attempt to prevent a suicide when they are on notice of a child or adolescent's suicidal intent" (Eisel v. Board of Education of Montgomery County, 1991, p. 456). The school counselors were viewed as having little discretion regarding whether or not to contact parents once information suggested a potential suicide.

The Eisel case and others (e.g., Kelson v. The City of Springfield, 1985) have been interpreted to suggest that schools should develop clear suicide prevention policies and procedures that include warning parents and should ensure adequate staff orientation to district policy and procedures. When it is suspected that a student is suicidal, the situation should be reported to the building principal and a designated staff member who has training in assessment of suicide lethality and suicide prevention. The school psychologist, counselor, or social worker might serve as designated staff. The student

717

should be assessed for the lethality of suicidal ideation because the degree of lethality determines the appropriate course of action (Poland, 1989). Most methods of assessing lethality involve seeking answers to a series of critical questions such as the following:

- Is there a preoccupation with death?
- Does the student have a suicide plan?
- Has the student made previous suicide attempts?
- Is there a history of past suicide in the family?
- Is the student involved with drugs?
- Has there been a precipitating event?
- Why does the student want to die? (see Berman & Jobes, 1991; Poland, 1989).

Practitioners are not expected to be able to predict suicide attempts with perfect accuracy, but they are expected to apply "skill and care in assessing suicidal potential and ... a reasonable degree of care and skill in preventing the suicide" (Knapp, 1980, p. 609). Many psychologists recommend asking suicidal clients to sign a "no-suicide contract." Although "do no harm" contracts may be clinically useful, it is important to recognize that such contracts do not substitute for a careful risk assessment and appropriate intervention based on the assessed risk (Simon, 1999).

Parents must be contacted in all cases, whether the risk is determined to be low or high. As Poland (1989) notes, the question is not whether to tell the parents, but how to elicit a supportive reaction from them. Parents of medium- or high-risk students should be contacted as soon as possible. The high-risk student should not be left alone, and his or her parents should be required to come to school for a conference and to pick up their child (Poland, 1989).

Poland (1989) recommends that two staff members conduct the parent notification conference and notes that some districts have parents sign a form acknowledging they have been notified their child is suicidal. The psychologist or counselor needs to ensure that parents understand the seriousness of the situation, and parents should be advised to increase supervision at home and remove access to weapons. The practitioner should be prepared to refer the family to a community mental health professional who has expertise in working with suicidal youths. Poland (1989) provides a number of recommendations for eliciting a supportive response from the parents. If parents are unwilling to follow through on treatment recommendations, however, Poland suggests it is appropriate to warn them that failure to seek assistance for their child is neglectful and that child protective services will be contacted.

Practitioners also need to consider the long-range needs of the suicidal student with regard to follow-up educational and mental health services. School personnel who work directly with a suicidal student should be informed so that they can provide adequate supervision (Poland, 1989). Some suicidal students may qualify for special educational services within the disability category of emotionally disturbed, or be eligible for an accommodation plan under Section 504 of the Rehabilitation Act of 1973.

Practitioners are well-advised to develop consultative relationships with clinicians who have expertise in suicide assessment and management whom they can contact for assistance in evaluating and managing a potential suicide situation (Jobes & Berman, 1993). Practitioners should document their actions regarding risk assessment and management of pupils who may be suicidal. They need to be familiar with community resources for referral, including the procedures for hospitalization of suicidal minors and adult students.

Issues Associated With Crisis Response

There is growing agreement among educators that safe school plans need to address crisis response. A school-based core team responsible for crisis management should be identified in the safe school plan and be trained to respond to unforeseeable events, including threats and incidents of violence (Dwyer et al., 1998; Pitcher & Poland, 1992). Crisis experts suggest a school psychologist or other school mental health professional be included in the development of the crisis response plan and as a member of the core crisis response team. To engage in actions that are likely to foster the well-being of students and others in crisis situations, the mental health professionals who serve on crisis response teams are ethically obligated to seek training in crisis response (PPE, II). Practitioners who are crisis response team members need multiple skills, including a sound knowledge of the stages of crisis development, understanding of common reactions of children and adults to various types of crisis situations, and competence in emotional first-aid techniques (Pitcher & Poland, 1992). In addition, teamwork is vitally important in crisis situations. Crisis team members must have well-developed consultation and communication skills. They also need to possess personal qualities that allow them to perform well in crisis situations (e.g., emotional and physical stamina, ability to control anxiety, skill in managing distraught and aggressive individuals) (Pitcher & Poland, 1992). Thus, school psychologists and other mental health practitioners should consider whether they are professionally and personally competent to assume a leadership role on the school's crisis response team, and whether they are the most competent mental health professional available to assume the role (PPE, II; EP Principle C).

School mental health practitioners, like other staff, should know and follow the procedures outlined in the school's crisis plan in a crisis situation. In addition, each practitioner should develop written procedures outlining his or her own role in crisis situations, and follow the steps outlined, including prompt notification of the specific individuals who are in charge of various types of crises (Pitcher & Poland, 1992).

School crisis response plans typically identify a trained spokesperson who is responsible for answering questions from the media to ensure there is no disclosure of confidential information and that pupil, staff, and family privacy are respected. Mental health professionals should refer questions from the media to the district spokesperson and take care not to inappropriately disclose confidential or private information in their interactions with students, staff, parents, or others (Poland & McCormick, 1999).

Consistent with the ethical principle of respect for autonomy and self-determination, mental health professionals should ensure that students not directly affected by the crisis are given a choice whether to participate in counseling sessions offered in the aftermath of a crisis (PPE, III, B, #3; EP 4.02). Practitioners will need to decide, however, whether participation in sessions to process the traumatic effects of a crisis should be mandatory for those students directly affected by the event (Peterson & Straub, 1992). Opportunities to discuss feelings and reactions in a supportive environment, and to have those feelings validated, may reduce the likelihood of posttraumatic stress disorder (Poland & McCormick, 1999). Mental health practitioners also will have to consider the rights of self-determination versus concerns for the psychological welfare of staff in deciding whether and for whom staff participation in crisis processing sessions should be mandatory.

Psychologists and other mental health professionals also have an ethical obligation to accept responsibility for ensuring that members of the school community have access to long-term support by identifying sources of support at school; providing referral information for community sources of assistance; and making follow-up contacts with students, staff, and families as appropriate to ensure they have been able to locate needed resources.

Summary

School administrators and mental health professionals are obligated to ensure that schoolwide efforts to promote a safe school environment do not violate the legal rights of pupils and their parents and that policies are planned and implemented in ways that are respectful of the dignity of individual students. Efforts to promote safe schools should be a reasonable exercise of the power and discretion of school authorities, related to the purpose of maintaining order to foster learning, and enforced in a nondiscriminatory manner. Although school children do not have the full range of personal rights and freedoms of adult citizens, schools may not arbitrarily trespass on their basic rights. Consequently, school officials must balance their interest in maintaining discipline with respect for the constitutional rights of students, including the right to freedom of speech and expression, right to be free from unreasonable search by school officials, right to due process prior to school suspension, the right to privacy of personal thoughts and beliefs, and the right to be free from unwarranted stigmatization by the school (inappropriate labeling). Schools must also consider the statutory protections provided by IDEA, FERPA, and other federal and state laws.

In addition to their interest in maintaining discipline to foster learning, schools generally have a duty to ensure the safety of students under their supervision. Consequently, psychologists and other school mental health professionals must be knowledgeable of the ethical-legal issues in responding to students who make threats to self or others as well as the issues associated with crisis response.

References

Alvarez, M. R. (1995). Do uniforms in public schools violate a child's first amendment rights? *Journal of Juvenile Law, 16*, 13-36.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychological Association. (1999). *Warning signs: A violence prevention guide for youth from* MTV *and* APA. Available Online: helping.apa.org/warningsigns/index.html

American Psychological Association. (2001). *The law and mental health professionals*. A series of books outlining mental health law state-by-state. (Editor and publication dates vary by state.) Contact APA for a list of available titles: www.apa.org

Americans with Disabilities Act of 1990, 42 U.S.C.S. § 12134 (LEXUS, 1999).

Berman, A. L., & Jobes, D. A. (1991). *Adolescent suicide assessment and intervention*. Washington, DC: American Psychological Association.

Bersoff, D. N., & Ysseldyke, J. E. (1977). Non-discriminatory assessment: The law, litigation, and implications for the assessment of learning disabled children. In S. Jacob (Ed.), *The law: Assessment and placement of special education students* (pp. 65-92). Lansing, MI: Michigan Department of Education.

Beussink v. Woodland R-IV School District, 30 F.Supp. 2d 1175 (D. E.D. Mo. 1998).

Borum, R. (2000). Assessing violence risk among youth. *Journal of Clinical Psychology, 56*, 1263-1288.

Borum, R., Fein, R., Vossekuil, B., & Berglund, J. (1999). Threat assessment: Defining an approach for evaluating risk of targeted violence. *Behavioral Sciences and the Law, 17*, 323-337.

Bradley, A. (1998, December 9). Student-survey dispute spawns more parent rights. *Education Week*, p. 3.

Burnside v. Byars, 363 F.2d 744 (5th Cir. 1966).

Civil Rights Act of 1964, 42 U.S.C.S. § 2000d (LEXUS, 1999).

Commonwealth v. Snyder, 413 Mass. 521, 597 N.E. 2d 1363, 1366 (Mass. 1992).

Corrao, J., & Melton, G. B. (1988). Legal issues in school-based behavior therapy. In J. C. Witt, S. N. Elliot, & F. M. Gresham (Eds.), *Handbook of behavior therapy in education* (pp. 377-399). New York: Plenum.

Davis, J. M., & Sandoval, J. (1982). Applied ethics for school-based consultants. *Professional Psychology, 13*, 543-551.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education. Available Online: www.ed.gov/offices/OSERS/OSEP/earlywrn.html

Education Amendments of 1972, 20 U.S.C.S. § 1681 *et seq*. (LEXUS, 1999).

Eisel v. Board of Education of Montgomery County, 597 A.2d 447 (Md. 1991).

Family Educational Rights and Privacy Act of 1974, 20 U.S.C.S § 1232 (LEXUS, 1999).

FBI Academy. (2000). *The School Shooter: A Threat Assessment Perspective*. Available Online: www.fbi.gov/

Ferraraccio, M. (1999). Metal detectors in the public schools: Fourth Amendment concerns. *Journal of Law & Education, 28*, 209-229.

Goals 2000: Educate America Act, 20 U.S.C.A. § 5801 *et seq.* (West Supp. Pamphlet 1997).

Goss v. Lopez, 419 U.S. 565, 95 S.Ct. 729 (1975).

Hummel, D. L., Talbutt, L. C., & Alexander, M. D. (1985). *Law and ethics in counseling.* New York: Van Nostrand Reinhold.

Hyman, I. A., & Perone, D. C. (1998). The other side of school violence: Educator policies and practices that may contribute to student misbehavior. *Psychology in the Schools, 36*, 7-27.

Individuals with Disabilities Education Act, 20 U.S.C.S. §§ 1400 *et seq.* (LEXUS, 1999).

In Interest of Isaiah B., 176 Wis.2d 639, 500 N.W. 2d 637 (Wis. 1993).

Improving America's Schools Act of 1994, 20 U.S.C.S. § 6301 *et seq.* (LEXUS, 1999).

James, B. (1997). FERPA and school violence: The silence that kills. In A. P. Goldstein & J. C. Conoley (Eds.), *School violence intervention: A practical handbook* (pp. 460-489). New York: Guilford Press.

Jacob-Timm, S., & Hartshorne, T. S. (1998). *Ethics and law for school psychologists* (3rd ed.). New York: Wiley.

Jobes, D. A., & Berman, A. L. (1993). Suicide and malpractice liability: Assessing and revising policies, procedures, and practice in outpatient settings. *Professional Psychology: Research and Practice, 24*, 91-99.

Kelson v. The City of Springfield, 767 F.2d. 651 (9th Cir. 1985).

Knapp, S. (1980). A primer on malpractice for psychologists. *Professional Psychology, 11*, 606-612.

Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology* (2nd ed.). New York: Oxford University Press.

Lawrence, R. (1998). *School crime and juvenile justice*. Cary, NC: Oxford University Press.

Merriken v. Cressman, 364 F.Supp. 913 (D.C. E.D. Pa. 1973).

Milligan et al. v. City of Slidell, No. 98-31335, 2000 WL 1285260 (5th Cir., Sept. 27).

Mirand v. Board of Education of the City of New York, 84 N.Y.2d 44, 637 N.E.2d 263, 1994 N.Y. LEXIS 1345. 614 N.Y.S.2d 372 (N.Y. 1994).

Nabozny v. Podlesny, 92 F.3d 446 (7th Cir. 1996).

National Association of School Psychologists. (2000). *Professional conduct manual.* Bethesda, MD: Author.

National School Safety Center. (1999). *Checklist for characteristics of violent youth.* Available Online: www.nssc1.org/

New Jersey v. T.L.O., 469 U.S. 325 (1985).

Olesen v. Board of Education of School District No. 228, 676 F. Supp. 820, 1987 U.S. Dist. LEXIS 13226 (D. N.D. Ill. 1987).

People v. Dukes, 580 N.Y.S.2d 850 (N.Y. Crim. Ct., 1992).

Peterson, S., & Straub, R. L. (1992). *School crisis survival guide: Management techniques for counselors and administrators.* West Nyack, NY: Center for Applied Research in Education.

Phillis P. v. Claremont Unified School District, 183 Cal.App.3d 1193 (Cal. Ct. App. 1986).

Pitcher, G., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.

Poland, S. (1989). *Suicide intervention in the schools*. New York: Guilford Press.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Protection of Pupil Rights Amendment, 20 U.S.C.S. 1232H (LEXUS, 1999).

Rehabilitation Act of 1964, 29 U.S.C.S § 794 (LEXUS, 1999).

Rapp, J. A., Carrington, F., & Nicholson, G. (1992). *School crime and violence: Victims' rights*. Malibu, CA: National School Safety Center.

Reddy, M., Borum, R., Vossekuil, B., Fein, R., Berglund, J., & Modzeleski, W. (2001). Evaluating risk for targeted violence in schools: Comparing risk assessment, threat assessment, and other approaches. *Psychology in the Schools*, 38, 157-172.

Reutter, E. E. (1994). *The law of public education* (4th ed.). Westbury, NY: Foundation Press.

Sales, B. D., Krauss, D. A., Sacken, D. M., & Overcast, T. D. (1999). The legal rights of students. In C. R. Reynolds & T. B. Gutkin (Eds.), *Handbook of school psychology* (3rd ed., pp. 1113-1145). New York: Wiley.

Schill, K. (1993, Fall). Violence among students: Schools' liability under Section 1983. *School Law Bulletin*, pp. 1-11.

School psychologists begin 'student profiling' to combat violence. (1999, September 7). *Midland Daily News*, p. A11.

Siegel, M. (1979). Privacy, ethics, and confidentiality. *Professional Psychology*, 10, 249-258.

Simon, R. I. (1999). The suicide prevention contract: Clinical, legal, and risk management issues. *Journal of the American Academy of Psychiatry & the Law*, 27, 445-450.

Simpson, M. D. (2000, February). After the shootings, lawsuits. *NEA Today*, p. 18.

Tarasoff v. Regents of California, 118 Cal.Rptr. 129, 529 P.2d 553 (Cal. 1974). (Tarasoff I) Tarasoff v. Regents of California, 131 Cal.Rptr. 14, 551 P.2d 334 (Cal. 1976). (Tarasoff II)

Taylor, L., & Adelman, H. S. (1989). Reframing the confidentiality dilemma to work in children's best interests. *Professional Psychology: Research and Practice*, 20, 79-83.

Telzrow, C. R., & Tankersley, M. (Eds.). (2000). *IDEA: Amendments of 1997*. Bethesda, MD: National Association of School Psychologists.

Thompson v. Carthage School District, 87 F.3d 979 (8th Cir. 1996).

Tinker v. Des Moines Independent Community School District, 393 U.S. 503, 89 S.Ct. 733 (1969).

U.S. Department of Education & Bias Crimes Task Force of the National Association of Attorneys General. (1999). *Protecting students from harassment and hate crime*. Available Online: www.ed.gov/offices/OCR/

Vossekuil, B., Reddy, M., Fein, R., Borum, R., & Modzeleski, W. (2000). *U.S.S.S. Safe School Initiative: An interim report on the prevention of targeted violence in the schools.* Washington, DC: U.S. Secret Service, National Threat Assessment Center. Available Online: www.treas.gov/usss

Endnotes

[1] The authors are not attorneys; nothing in this chapter should be construed as legal advice. School personnel are urged to consult their school attorney when legal questions arise., Some material in this chapter was adapted from S. Jacob-Timm and T. Hartshorne (1998), *Ethics and Law for School Psychologists*.

[2] Copies of state laws affecting education can typically be purchased from a state's department of education, downloaded from its website, or located in a college library law collection. State psychological associations often disseminate information regarding state mental health laws. In addition, the American Psychological Association (2001) publishes *The Law and Mental Health Professionals*, a series of books outlining mental health law in each state.

[3] For more detailed information regarding discipline of students with disabilities under IDEA, see *IDEA: Amendments of 1997* (2000), edited by C. F. Telzrow & M. Tankersley, and published by the National Association of School Psychologists, Bethesda, MD.

[4] References to the National Association of School Psychologist's (2000) "Principles for Professional Ethics" will be abbreviated "PPE." References to the American Psychological Association's (1992) "Ethical Principles of Psychologists and Code of Conduct" will be abbreviated "EP."

35

危
機

Advocating for Crisis Prevention and Intervention

Libby Kuffner Nealis, M.S.W.
National Association of School Psychologists

The Chinese translation for the word "crisis" consists of two symbols: one meaning "danger," the other meaning "opportunity." This perspective of the word crisis opens up a world of possibility not usually connected to the feelings associated with crises. This is a most positive perspective for treating a victim in clinical practice and is an equally positive perspective for advocacy.

Acknowledging the need for crisis intervention practice and procedures is only part of the advocate's task. Shaping these policies and practices via legislation clearly presents us with both opportunity and danger. When policymakers only hear one side of the story (e.g., law enforcement leaders hardened by the multitude of youngsters they view as "beyond rehabilitation," or superintendents "burdened" by students with challenging behaviors), schools—or at least the youths in question—may end up worse off than they were before. However, if educators use their experiences with youths—both those exposed to crises and those fortunate enough to have been spared thus far—policymakers and legislators can gain keen insight on effective programs and what works to create positive results.

This chapter begins by examining what policies exist, or have been proposed, regarding crisis intervention in schools and communities. The unfortunate reality is that few, if any, formal guidelines in federal or state statutes give direction or recommendations to schools, community centers, or even juvenile detention centers on how best to proceed during or after a crisis. In fact, there is no definition of what might constitute a crisis or other situation calling for attention or follow-up services … at least not yet. Given this reality, I explore the need for continued advocacy efforts. The chapter concludes with a discussion of how individuals can advocate for crisis prevention and intervention at the local, state, and federal levels. The obligation to provide crisis services or to establish intervention and prevention guidelines is the responsibility of those advocates who acknowledge that such guidelines and services are beneficial. The majority of lawmakers do not understand what it takes to address the needs of students, families, and school staffs after traumatic events occur. Thus, it is essential that they continue to hear from advocates who do understand.

Recent Advocacy Products and Efforts

Laws and Federally Sponsored Guidelines for Prevention

Early Warning, Timely Response. After a series of school shootings in West Paducah, Kentucky, Jonesboro, Arkansas, and Springfield, Oregon, the Clinton Administration responded with a White House Conference on School Safety in October 1998 and helped to produce *Early Warning Timely Response: A Guide to Safe Schools* (Dwyer, Osher, & Warger, 1998) and the companion guide, *Safeguarding our Children: An Action Guide* (Dwyer & Osher, 2000). These were only first steps of many still in progress to improve crisis prevention and preparedness in schools. As part of the fiscal year (FY) 2000 federal spending plan, Senators Arlen Specter (R-PA) and Tom Harkin (D-IA) highlighted and strengthened a number of existing programs to assist in promoting school and community safety and reducing youth violence: the *Youth Violence Prevention Initiative* (Senate Report 106-166). Although extremely important and beneficial to the cause of violence prevention and positive youth development, these programs are either block grants or competitive grants. None are mandates, and all are granted with flexibility of design and implementation practice. Still, guidance and oversight are critical.

Examples of the federally funded programs implementing these recommendations include (a) the Safe Schools/Healthy Students Initiative, and (b) the School Action Grants Program. The former program is a collaborative effort among the Departments of Health and Human Services, Education, and Justice. This program has awarded grants totaling more than $180 million in FY2001 to approximately 77 local educational authorities and their mental health and law enforcement partners to promote healthy childhood development and prevent violent behaviors. The School Action Grant Program is a school violence-prevention effort launched by the Centers for Mental Health Services in collaboration with the Center for Substance Abuse Treatment. This program awarded $5.7 million in FY2001 to encourage communities to implement effective programs and practices to promote healthy childhood development and prevent youth violence and substance abuse.

Individuals with Disabilities Education Act (IDEA). IDEA 1997 Amendments (Public Law 105-17) and corresponding regulations [U.S. Department of Education, Office of Special Education and Rehabilitative Services (OSERS), 1999] clarified many of the guidelines for schools and districts to follow to comply with the law. For example, the 1997 Amendments added "new provisions that require schools to assess a child's troubling behavior and develop positive behavioral interventions to address that behavior, and that describe how to determine whether the behavior was a manifestation of the child's disability" (U.S. Department of Education, OSERS, 1999, p. 8). However, the procedures to follow when a student becomes violent or possesses weapons or drugs mainly deal with the removal of the student and/or a change in placement. Unfortunately, as illustrated by the debates over the challenges of the law, the school administrators' focus in complying with IDEA has become about how to pay for the services they are required to provide and avoid being sued for noncompliance. Within the context of a manifest determination, the administration assesses the causes of a particular behavior and reviews the Individualized Education Plan (IEP) and/or Behavior Intervention Plan (BIP) to determine if appropriate interventions were in place to prevent the problem behavior. If the behavior constitutes a violation of law, as in the case of drugs, weapons, or firearms, the schools is free to contact local law enforcement. Once the student is taken into legal custody, it is likely that even fewer, if any, interventions will be implemented. This is a frustrating aspect of what constitutes "intervention" because now the question of services, if any, falls on local law enforcement officials. Whose responsibility is it to provide and pay for services? For many advocates, and those with a greater understanding of what is at stake, the more important questions are: What are the most appropriate services? Who is best suited to provide them? And how soon and how often should they be provided?

Leaders of the education community generally agree that, if school authorities believe a student presents a danger to him- or herself or others, the school should remove that student to protect the safety of the other students and school personnel. In a juvenile detention center, the youth will likely be placed in isolation. Perhaps a school psychologist or other professional with crisis intervention training will be called to assist. No formal federal guidelines, however, require that this take place. In fact, most proponents of "smaller" government believe that this type of policy should be left to the discretion of the local school district. Given the current situation, it often falls on local school mental health professionals, parents, or other child advocates to insist that school districts have procedures in place that recognize the importance of crisis intervention and postvention practices.

Suicide prevention. Unfortunately, suicide prevention and intervention is another area that has been neglected in federal policy. In 1996, the year for which the most recent statistics are available, suicide was the ninth leading cause of mortality in the United States and was responsible for nearly 31,000 deaths. It is the third leading cause of death for Americans aged 15 to 24 years, second only to accidents and homicide. This nation must address suicide as a significant public health problem and put into place national strategies to prevent the loss of life and the suffering suicide causes [Centers for Disease Control (CDC), 1999].

Public and private agencies collaborated in a national conference on suicide prevention convened in Reno, Nevada, in October 1998. Conference participants included researchers, health and mental health clinicians, policymakers, suicide survivors, and community activists and leaders. Their report and subsequent action on what is known and unknown about suicide, and its potential responsiveness to a public health prevention model, culminated in *The Surgeon General's Call To Action To Prevent Suicide* (CDC, 1999).

In July of 1999, Tipper Gore and Surgeon General David Satcher unveiled a blueprint—Awareness, Intervention, and Methodology, or AIM—to prevent suicide in the United States. This document outlines more than a dozen steps that can be taken by individuals, communities, organizations, and policymakers. AIM includes 15 key recommendations that were refined from consensus and evidence-based findings presented at the Reno conference. Unfortunately, these are recommendations, not mandates. Implementation of these practices still requires advocacy by interested parties such as school mental health professionals.

Fortunately, authorization of programs to improve access to children's mental health services and interventions made some significant gains through recent legislation. On October 17, 2000, President Clinton signed the Children's Health Act into law (Public Law 106-310). This measure, an omnibus package of legislation reauthorizing programs ranging from research on children's health problems to substance abuse prevention and treatment, encourages a greater focus on youth violence and drug use. It authorizes $100 million in grants to public entities to help fight youth violence. Another $50 million will be authorized to research psychiatric disorders among children who have witnessed domestic or community violence. It includes a new initiative to train teachers, relevant school personnel, and emergency service personnel to recognize symptoms of childhood and adolescent mental health disorders and to provide education and links to community resources for individuals in need.

This type of legislation, however, does not fund these programs. Funding of these programs adequately, if at all, is left to a completely separate annual appropriations process. Each year, advocates must fight to sustain or increase funds in programs they support. Again, advocacy is needed to bring these programs from legislation to practice. The fact that an authority such as Surgeon General Dr. David Satcher brought high visibility to the issues of children's mental health (U.S. Department of Health and Human Services and U.S. Public Health Service, 2000; CDC, 2001) and suicide (1999) as major preventable public health problems is a victory for crisis prevention and intervention advocates. Such federally appointed officers, however, can only bring research to the forefront and propose recommendations. They cannot force policy or enact legislation. Only Congress can do so. Thus, it is up to advocates to encourage and persuade elected officials to further advance these issues, by using the data, the documentation of experiences, and the stature of a Surgeon General's report (and other research) to support the effort.

In rare cases, a program can be funded before being authorized by separate legislation. One example is Project SERV (which stands for School Emergency Response to Violence). According to the Department of Education's Office of Elementary and Secondary Education (OESE) (1999), programs like Project SERV "Help schools respond to a violent or traumatic crisis and improve our ability to respond to serious school violence" (p. 32). The Secretary of Education would be authorized, in consultation with the Attorney General, the Secretary of Health and Human Services, and the Director of the Federal Emergency Management Agency (FEMA), to deploy rapid assistance to school districts that have experienced violent or other traumatic crises that have disrupted the learning environment. As proposed, Project SERV will provide, among other things, mental health crisis counseling to students and their families, teachers, and others in need of such services.

Project SERV was awarded $10 million for fiscal year (FY) 2001 to use at the discretion of the Department of Education. The National Association of School Psychologists (NASP) is currently working with the Department to ensure the involvement of school mental health professionals and its National Emergency Assistance Team (NEAT) in this postvention effort. While the idea behind a proposal such as Project SERV is critical intervention, it only addresses the after-effects of school violence. NASP advocates greater emphasis on fostering ongoing preventative community and school-based mental health services. School mental health professionals and other educators must continue to promote the inclusion of legislative language that requires schools and/or communities to provide appropriate supervision, counseling, and educational services to suspended or expelled students.

Proposed Legislation

Regarding federal legislation, only small steps have been taken to require schools and communities to acknowledge the importance of crisis prevention. For example, in August of 1999, Senators Pete Domenici (R-NM) and Ted Kennedy (D-MA) introduced S. 1555, the "Health Response to Youth Suicide and Violence Act of 1999." It was referred to committee, but never considered. In September of 1999, Representatives Ron Packard (R-CA) and Mark Udall (D-CO) introduced House Resolution 286 "Recognizing that prevention of youth suicide is a compelling national priority." While well intentioned, such resolutions have little impact. The House never passed this resolution, even as a symbolic gesture. Clearly, champions for these causes exist, but there is minimal political will to pass such proposals into law. Furthermore, the federalist movement in Congress for state's rights would insist that it is up to individual states and localities to enact such laws. To compel Congress into establishing a federal priority or guidance to states to enact such policies will take increased grassroots advocacy from the mental health community and increased constituent appeals to representatives.

Educational Excellence for All Children Act. At the beginning of the 106th Congress, the Department of Education released its recommendations for the Reauthorization of the Elementary and Secondary Education Act (ESEA) of 1965 (PL 103-382), the single, largest federal education bill. Various sections of this proposal added or strengthened provisions to enhance school safety and crisis response.

Although the Clinton Administration's proposals did not become law, some of the ideas, mentioned below, represented important advancements in school-based services. Unfortunately, the Republican-controlled majority in Congress touted them as expanded big-government intrusions or duplicative, unnecessary new programs. Such efforts are completely excluded from the Bush Administration's proposal, "No Child Left Behind." Mental health and education advocates are certain that the creation of such prevention and intervention programs, or at least guidance for state and local school authorities to administer research-based exemplary programs, is exactly what is needed.

The Clinton Administration's proposal offered to amend Title IV of ESEA, the Safe and Drug Free Schools (SDFS) Program, to require "an individual evaluation of students who bring a firearm to school and continue educational services for these students" (Department of Education, OESE, 1999). This proposal also would have modified the Gun-Free Schools Act (GFSA)—first added during the 1994 reauthorization of ESEA—to require that students found in possession of a firearm in school be assessed to determine whether they pose an imminent threat of harm to themselves or others. "To ensure that these students remain connected to stable supervised environments, students would have to receive appropriate counseling, supervision, and educational services while they are out of school, and appropriate treatment before they can return to school"(Department of Education, 1999, p. 28). While this language may seem like a simple, obvious intervention for youths who carry weapons to school, it was not passed into law and is not included in pending ESEA language

Prevention of juvenile delinquency. Congress continues to attempt to reauthorize the Juvenile Justice and Delinquency Prevention Act of 1974 (PL 93-415). In the past decade, policymakers and legislators at the federal, state, and local levels have considered various approaches, such as implementing evening curfews and increasing schoolyard security patrols, to reduce youth violence and prevent juvenile crime. Thus far, the role of crisis intervention has only been remotely considered in some states. Instead, a "get tough on crime" approach has been the overriding trend, emphasizing punishment and accountability as opposed to prevention and treatment. This approach is evidenced even in the title of one proposed bill: the Violent and Repeat Juvenile Offender Accountability and Rehabilitation Act of 1999 (S. 254/H.R. 1501).

After the tragedy at Columbine High School, the U.S. Senate debate on juvenile justice legislation turned. For the first time, the connections among a student's emotional well-being, school violence, and juvenile crime were made during substantive floor debate. The idea of providing mental health assessments and services to youths in detention, or providing crisis intervention to both the perpetrators and victims of school violence, was finally given legislative consideration. As evidenced by the amendments that have been passed and the programs that have been funded, prevention is still largely discussed as a matter of more strict discipline codes and increased school security efforts.

Opportunities. Some positive provisions have been discussed in pending juvenile justice legislation (such as the aforementioned S. 254). For instance, the Juvenile Delinquency Prevention "Challenge" Block Grant program was amended to allow the funds to be used for projects that support state and local programs to prevent juvenile delinquency by providing for:

- assessments by qualified mental health professionals of incarcerated juveniles who are suspected of being in need of mental health services;
- the development of individualized treatment plans for juveniles determined to be in need of mental health services;
- the inclusion of discharge plans for incarcerated juveniles determined to be in need of mental health services; and
- requirement that all juveniles receiving psychotropic medication be under the care of a licensed mental health professional.

These provisions are all critical interventions for youths within the juvenile justice system, but we still need greater emphasis on preventing youths from entering the system.

Dangers. Unfortunately, such positive additions are juxtaposed with disappointing inclusions and exclusions, not to mention they are packaged in what is considered by youth advocates to be an overly hostile, unjust piece of legislation. For example, the proposed S. 254 would eliminate the coordinating council on Juvenile Justice and Delinquency Prevention and would create new grant programs such as CRISIS—Confidential Reporting of Individuals Suspected of Imminent School Violence. CRISIS funds would provide for a 24-hour telephone hotline and boot camps but would remove federal language against hate crimes. It would expand drug testing (in the absence of substance abuse treatment), use of probation officers, and hiring of prosecutors. The bill removes authorization for treatment programs for juvenile offenders who were victims of child abuse and neglect and educational programs to provide alternatives to suspension and expulsion.

Although many of the legislative proposals discussed in this chapter are from past Congressional sessions, they do offer clear examples of the conflict between what research confirms as effective, and what Congress attempts to legislate. I assert that such proposed changes in law reflect a harsh view of youths and a negative prognosis for rehabilitation and prevention. Rather than using the research on effective intervention programs and sufficient funding to implement cost-effective prevention, the presiding lawmakers have chosen to take a more punitive approach, with little insight and lack of foresight about what is good for kids.

Further debate on the issues of gun control and youth violence, or what some view as "youths out of control," has provided Congress with the opportunity to debate discipline in the schools. Naturally, the IDEA discipline provisions came under attack. Because of the perpetuation of misinformation and accounts from school leaders based on pre-final regulation (U.S. Department of Health and Human Services, OSERS, 1999) data, certain members sought to amend this provision in the guise of school safety. Two amendments passed by overwhelming majorities during the 106th Congress: the Frist (R-TN)/Ashcroft (R-MO) amendment passed 76 to 24 in the Senate (S. 254) and the Norwood/Barr (both R-GA) amendment passed 300 to 128 in the House (H.R. 1501). The amendments were then attached to the Juvenile Justice legislation. The amended language would level the discipline playing field and calls for the removal of *any* student and cessation of services for bringing a firearm or weapon to school.

Representatives Norwood (R-GA) and Barr (R-GA) again introduced the IDEA discipline amendment during House consideration of ESEA in 2000 and 2001. This amendment would mandate that any student (including a child with a mental illness or severe emotional disability) who brings a gun, weapon, or drugs to school would automatically be expelled from school for one year without the opportunity to receive any educational services. Such language would eliminate community schools, expulsion centers, or any other options for students who have been expelled, unless separate state law mandated it (and thus paid for it). Further, this language would cease any other services, such as mental health or behavioral interventions, to which the student was entitled as part of his or her IEP. In other words, the student would be out of school with no supervision or accountability.

Although controversial gun-safety provisions blocked this legislation from becoming law, opposition to IDEA discipline provisions, and other proposals that reflect punishment rather than intervention, will likely return during similar debates on juvenile crime, student discipline, and/or gun safety. Therefore, it is critical that we continue to advocate for services for all students who have been suspended or expelled.

The Need for Continued Advocacy

In an effort to oppose IDEA discipline amendments and promote services, NASP and the Council for Exceptional Children (CEC) have joined with other mental health and education colleagues in a "No Cessation" campaign as part of a Safe Schools/Safe Streets initiative. NASP and CEC propose that payment for these services fall not on the schools alone, but jointly on the mental health and juvenile justice community. Raising the bar of services for *all* students is the most effective means of preventing juvenile crime and encouraging students to continue their education. In other words, the "level playing field" needs to be at a higher level.

Lawmakers and state officials appear more concerned with raising standards of achievement and student testing, while most school administrators are more concerned about meeting what they consider to be the main priorities of the educational institution—usually within the framework of the given calendar school year and typically tight budgets. School mental health personnel have an opportunity to engage these leaders in a dialogue about needed services and how such services benefit the emotional and psychological needs of the school community. However, even when such leaders are in agreement regarding the need for mental health service, they often respond: "But who will pay for these services?"

Education and mental health advocates are constantly faced with this same question. One often wants to shout from the hilltops, "Who cares who pays? Let's just get these services out there!" It is first the responsibility of government officials to respond to public need (and public opinion) and agree that something deserves national attention and/or funding (such as school and community-based crisis intervention). Then it is the government's responsibility to determine how to fund it. While financial restraints are the reality, the "who pays?" response is simply unacceptable when considering the safety and well-being of this nation's youths.

Throughout recent House and Senate negotiations on juvenile justice and education reform, various proposals have revealed an idea that keeping schools safe means removing students with "persistently disruptive behavior." Thus, eliminating the provisions in IDEA to conduct a manifest determination and continue to provide Free and Appropriate Public Education (FAPE) (U.S. Department of Health and Human Services, OSERS, 1999, p. 3) would lead to a disproportionate number of students with disabilities being removed from school. This is precisely the reason why the discipline protections were included in the IDEA 1997 amendments.

Law enforcement agencies across the country agree that ceasing education services for any child only increases juvenile crime [U.S. Department of Justice, Office of Juvenile Justice & Delinquency Prevention (OJJDP), 1999]. In fact, research demonstrates that cessation of education services leads to increases in juvenile crime, dropout rates, incarceration, and illegal drug use (Larson, 1995; Wagner, 1991). Rather than releasing troubled children to the streets, part of the solution should be to mandate that students who are expelled or suspended continue their education in secure, supervised educational settings. Alternative education programs and services help ensure safe schools *and* safe streets, and that all children and youths have a safe learning environment in which to succeed.

Barriers to Learning

School mental health and other pupil services personnel support effective learning environments by (a) providing research-based consultation and intervention services to teachers; (b) implementing effective classroom learning and behavioral activities for students; (c) utilizing their skills in assessment to ensure that curriculum, instruction, assessment, and intervention are linked for each child; and (d) encouraging family involvement in their children's education. Research has demonstrated that, when teachers are supported with ongoing consultation from trained professional teams, they can address more effectively barriers to learning (Adelman & Taylor, 2000). The current research cited in the Institute of Medicine's report (1997), *Schools and Health* suggests that some of the most significant barriers to learning are psychological, emotional, and behavioral. The most skilled and experienced teacher may not be able to meet the needs of students who have significant barriers to learning.

Reports from the Center for Mental Health Services (CMHS, 1996b) state that the prevalence of serious emotional disturbance is higher among children of poverty and that "5-9% of all children have extreme psychosocial functional impairments to academic learning" (p. 85). Additionally, numerous studies show a strong correlation between the provision of adequate mental health services and decreases in delinquent behavior, substance abuse, and the incidence of school violence (National Center for Education Statistics, 1998). Prevention programs and intervention services help reduce classroom disruption and the fear of violence, which enables children to learn.

Unfortunately, existing service provider ratios in this nation's schools are inadequate to meet the needs of students, teachers, and parents. Because school psychologists are forced to work in a triage of crisis intervention, there is little or no time for prevention. The current national average school psychologist to student ratio is 1:2,100 in elementary and secondary schools (CMHS, 1996a). This average is more than double the 1 school psychologist to 1,000 student ratio (or 1 to 100 for students identified as disabled and needing special education) recommended by the American School Health Association (ASHA, 1999) and the Institute of Medicine (1997). Although 7.5 million children under the age of 18 require mental health services, it is estimated that fewer than one in five receive the help they need (U.S. Public Health Service, 2000).

NASP believes lawmakers must authorize and appropriate adequate funds for schools to hire qualified professionals to address the mental health needs of students. But bear in mind, Congress considers the word "mandate" a dirty word (yet another challenge). The mantra is no mandates and state flexibility. Regardless, at a minimum, federal guidance should assist states in coordinating schoolwide intervention and prevention programs and consultations that address both the learning and behavioral needs of all children. Furthermore, federal guidance and research dissemination should support inclusion of pupil services to help meet the mental health, educational, and behavioral needs of all children, especially the most vulnerable, as well as foster school environments that are safe, conducive to learning, and drug-free.

Poor administrative policies, limited resources, and competing priorities have worsened the situation for school mental health services. Existing services are often prioritized to comply with special education regulations rather than to serve children. School psychologists spend less than one-third of their time providing direct service or consultation services to children, teachers, and parents and more time dedicated to mandated special education eligibility evaluations and procedural meetings, resulting in a lack of service to many needy students (Dwyer, 1995). Students placed in special education and those at risk account for a high percentage of school dropouts and unemployed adults (Hodgkinson, 1995).

Zero Tolerance

Common sense would suggest that school and community leaders want to minimize the threat of school violence. They see troubled students as a liability and want them removed from schools—so they complain to elected officials. A common suggestion is to implement strong zero-tolerance policies, perhaps so they can "get rid of the troublemakers." Rather than implementing programs and services that require an initial financial investment, but are shown to be cost-effective in the long run, politicians and even administrators usually look for quick fixes that can show some immediate results (and win them re-election). In any case, few politicians will commit additional taxpayer dollars for what are viewed as "unproven" school mental health services and intervention programs—despite the fact that polling data [Wilgoren, 2000; National Education Association (NEA), 2000] confirm public support of education and delinquency preventive programs for youths in exchange for larger tax cuts.

As discussed above, Congress has passed amendments to IDEA that would cease education services for any student who possesses guns, weapons, drugs, commits assault, or even threatens assault on school property or while at a school function. If this language becomes law, it follows that the need for alternative services will become even greater. While a portion of Safe and Drug Free Schools Programs' state grants may be used to establish or expand alternative education and services, this only applies to those states that already have alternative programs and services in place and to those districts with the resources to apply for such grants. Stronger language is needed to support and strengthen alternative education and services. To ensure safe schools and communities, while promoting academic success for all students, youths must have access to continued educational opportunities and necessary services in a supervised environment. Coordinated, research-based alternative programs and timely interventions will improve both educational and social outcomes for any child. To be most effective, efforts must be coordinated at the local and state level and supported by the federal government, educators, law enforcement authorities, mental health and substance abuse services, parents, and community groups. Therefore, federal legislation is necessary to provide states with the resources and support needed to coordinate these efforts. Currently, only 15 states have laws addressing the need for alternative education and services.

Elected officials cannot ignore the need for prevention and intervention and allow troubled youths, who need guidance and training, to roam the streets unsupervised, roam school hallways unattended, or sit in detention centers and jails without services.

So how can we communicate this message of prevention? In a political environment where tax cuts and limited government spending has become the praised goal, how do educators persuade the community and taxpayers to pay the additional dollars needed to support school-based mental health services, prevention, and crisis interventions? The majority of the public and policymakers believes the emphasis must be placed on education spending and support for teacher quality. Strong and continuous professional development for teachers and recruitment of a strong teaching force are absolutely needed. But as school mental health professionals and many other educators know, teachers cannot function effectively in isolation. Teachers need other pupil services personnel to complement an overall support system that prevents students' behavioral problems from escalating.

In 2000, I met with a congressional staffer from the House Education Committee (who will remain unnamed) who actually stated, "if we gave teachers all they needed to do their jobs, there would be no need for professionals such as school psychologists." Academics aside, with concerns over discipline, crisis intervention, and preventing school violence, how can teachers and administrators possibly be expected to embody all the skills and perform all functions of specialists with post-graduate degrees and training? Furthermore, multidisciplinary teams of teachers and other professionals have been proven to be the most effective means of addressing the multiple needs of students. The reality of this explanation seems to be disregarded. Practitioners (as constituents) must inform and educate lawmakers and staff who have such misperceptions. This area is where practitioner advocacy efforts can be most helpful.

How to Advocate

School mental health professionals have the knowledge and skills to advocate effectively for children and for their profession. The discussion that follows provides basic information on ways in which each and every educator can help shape public policy and increase funding for prevention services through involvement in government relation activities at the local, state, or national level.

Whatever the level of effort, be it local, state, or national, it is important to evaluate existing and needed resources as they relate to any government relation mission. Several critical factors in this analysis are parallel to the information gathering and analysis that school mental health professionals use within their professional lives. These factors include problem identification, goal setting, and analysis of strengths and weaknesses as they relate to a stated mission. School mental health professionals are experts in teamwork, measurement, research, and communication. They are also experts in effectively tackling a problem with an outcome-based approach, using measurable goals. These skills can be easily adapted to advocacy and should be used in all government relation activities.

Unfortunately, research alone will not achieve the desired goal to expand and improve prevention and services. The effort must be combined with the political power of school mental health professionals (joined by like-minded child advocates) to influence public policy for the benefit of children, families, and schools. It is important to not let the term "political power" be intimidating. To some it implies the need for a political action committee (PAC) and large financial backing to make any impact. This is FALSE. Political power is nothing more than the willingness, dedication, and commitment to speak up and inspire others to join in with their voices. As mentioned above, elected officials are obligated to listen to constituents and consider their views.

With that said, the question is not, "Is one willing?" but "What does one say and when?" Fortunately, this process is relatively easy. For example, the NASP Government and Professional Relations (GPR) Committee and staff have developed and strengthened the information systems and the network within which this information is shared. The School Psychology Action Network (SPAN) is the mechanism through which policy and legislative information is shared.

The School Psychology Action Network (SPAN)

At the top of the network chain, the NASP GPR Committee and staff provide information and action requests regarding pending and ongoing policy opportunities for school psychologists and other advocates to impact services to children and families. The next tier of the Action Network is the State SPAN Coordinator. Each state chooses a State SPAN Coordinator to help develop and expand this network within each state. How each state chooses to develop this position is up to the state leadership. Ideally, this person would be the legislative chair or a member of a government relations committee. The basic idea is that this legislative chair or "action coordinator" helps coordinate legislative activity and motivate state members to get involved. Acting as a liaison between the state and the national association, this person can share information and minimize response time. Moreover, the information dissemination and action requests at the national level can be a model for action at the state and local level. NASP has established training programs to assist states in expanding on the methods and techniques of developing a state plan for advocacy action and strengthening their state associations to respond to professional and political issues. Similarly, other organizations have developed training for state and federal advocacy.

Using the Internet and E-Mail

Cyberspace has revolutionized the art of advocacy. Once online, advocates can access all the information needed, including background information on bills and proposals (federal, state and, in many cases, local), when votes are taking place, and how members voted on a particular issue.

To assist its members in connecting to the World Wide Web and gathering information, the NASP Web Page, *www.nasponline.org*, offers many links to helpful and informative websites. NASP and many other advocacy groups have harnessed the power of Internet advocacy and have made state and individual involvement as easy and convenient as possible. See Table 1, on page 746, for additional websites.

Table 1

Some Suggested Websites for Advocates

thomas.loc.gov
The official U.S. Library of Congress website with bill tracking, bill and Public Law texts, Congressional schedules, and much more.

www.whitehouse.gov
The official site of the White House, with links to a multitude of agency and departmental sites under the Executive Branch.

www.ed.gov
U.S. Department of Education's extensive site, including grant information and program descriptions.

www.ed.gov/offices/OSERS/OSEP
Office of Special Education Programs (OSEP).

www.pbis.org
OSEP Technical Assistance Center on Positive Behavior Interventions and Supports.

www.air.org/cecp
Center for Effective Collaboration and Practice.

www.edjj.org
National Center on Education, Disability, and Juvenile Justice.

www.ed.gov/offices/OESE/SDFS
Office of Safe and Drug-Free Schools.

www.samhsa.gov
Substance Abuse and Mental Health Services Administration site, including the Center for Mental Health Services (CMHS) and the Safe Schools/Healthy Students Program.

www.mentalhealth.org
The Knowledge Exchange Network.

www.cdc.gov/ncicp
Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, including information on school safety and violence prevention.

www.surgeongeneral.gov
Links to reports from the Surgeon General on mental health, children's mental health, and youth violence.

www.ojjdp.ncjrs.org
Office of Juvenile Justice and Delinquency Prevention, National Criminal Justice Reference Center.

www.bphc.hrsa.gov and *www.hrsa.dhhs.gov/childhealth*
Health Resources and Services Administration (HRSA).

www.mchb.hrsa.gov/index.html
Maternal and Child Health Bureau.

www.acf.dhhs.gov/programs/ccb
Child Care Bureau.

www.hcfa.gov/init/children.htm
Health Care Financing Administration (HCFA), with information on school-based Medicaid services and Children's Health Insurance Program (CHIP).

www.insurekidsnow.gov/
Insure Kids Now, also national toll free number: 1-877-Kids-Now.

For more national organizations and general education information go to:

www.edweek.org
Education Week, a monthly newspaper on education policy and legislation at all levels across the nation. Free archive search by subject.

www.nea.org
National Education Association.

www.childrensdefense.org
Children's Defense Fund.

www.cwla.org/health/healthfact.html
Child Welfare League of America.

www.aecf.org/aeckids.htm
Kids Count data and other useful information from the Annie Casey Foundation.

Educators can use the Internet to respond and advocate when a pending legislative proposal could increase support and/or funding for school or community-based prevention or intervention services. For example, professional associations can use the online Advocacy Action Center, such as is offered to school psychologists by NASP, to disseminate legislative alerts and/or to send already composed letters to Congress. Educators can also quickly send messages via e-mail or fax to elected officials regarding the most current and critical issues affecting students. It takes only minutes to get messages to important policymakers. Advocates may also use the information on elected officials to get local contact information and phone numbers to contact offices or even arrange a visit.

E-mail has become the most widely used advocacy tool of the day. The vast majority of legislators are very interested in the e-mail they get from constituents; however, the effectiveness of e-mail correspondence over regular mail varies from office to office. In some cases legislative offices may set up an auto reply to e-mails. This does not mean the message has not been read; rather, it is simply a way of letting people know the message has been received and making it clear that legislators will only respond to messages sent by constituents. In some cases the office will request an alternate method of communication they may prefer. If a given office does not like e-mail, I recommend that one prints the message and sends it via U.S. mail. Alternatively, one might call legislative offices and use the message as a script.

Many lawmakers are bombarded by e-mail. Approximately 90% of these e-mails are not from the member's state or district, and members are not obliged to heed the messages of anyone but their own constituents. Thus, constituent senders must include their address on an e-mail in order to be acknowledged. To manage the barrage of e-mails, lawmakers and members of Congress often use filtering systems that search for addresses within the member's congressional state or district and expedite the retrieval of these messages, deleting the others. Internet consulting firms have also developed packages that assist an office in responding to these constituent e-mails. Depending on the system employed by a particular office, e-mails may trump written letters in reaction time and execution of a response.

Many people are concerned that e-mail will not be read; however, statistics show that close to 60% of adults are on the Internet and use e-mail (Bennett & Fielding, 1999). This computer-savvy group, which consists equally of men and women, is mostly married adults with children, and with college or more education. Politicians are well aware of how many voters are using e-mail and can hardly ignore it.

Of course, letters via U.S. mail, phone calls, and office visits are still of great value and should be used by advocates whenever possible, particularly when time is of the essence. In fact, it often reinforces a message to follow up with a phone call or mail a hard copy of a letter that has already been faxed or e-mailed. Certainly, this takes more time and is over and above the call of duty for most educators. Educators should take whatever steps they can to participate, and should not resist involvement for fear it may take too much time. Cyberspace has already made advocacy much easier than before. Moreover, elected officials and their staffs, as well as advocates who have achieved success, can attest to the effectiveness of constituent communication.

Listservs: Receive Information and Network With Colleagues

Most Internet and e-mail services allow one to create address groups and send e-mails to a list of people by selecting the name of the group. This is a great way to pass along information (e.g., the NASP Legislative Update or other relevant group information can easily be forwarded to other educators and coalitions).

Listservs either deliver one-way information (such as the NASP Legislative Update) or allow discussion via e-mail between groups of people. Each listserv gives specific instructions on how to sign on. The two types of listservs, moderated and unmoderated, each have pros and cons. The former type controls the flow of information to avoid back and forth discussion. For some purposes, however, discussion on an unmoderated listserv allows professionals and colleagues to share ideas across the country and around the world.

Educators can track and influence policy making at the federal level through the NASP website and other sites, the SPAN Listserv (with weekly Legislative Updates and periodic Legislative Alerts), and various articles in professional newsletters such as the quarterly *SPAN Update Newsletter*. Information is available from professional organizations, such as NASP, and at the state and local level through various state organizations and local campaigns. Just as school psychologist involvement is encouraged at the national level through the NASP Advocacy Action Center, the same procedures can be used to contact state and local government officials. It is the obligation of professional associations and state leaders to encourage continued tracking of important policy issues and to empower their state associations to keep members informed.

Being an Advocate

Service implementation requires proof of improved outcomes. Communities should support services that result in increased education and graduation rates, employment and independence, and reduced violence and substance abuse. What are these services and who is qualified to provide them? Should federal or state funds pay for services that are only somewhat effective or provided by unqualified or even underqualified professionals? Accountability must be improved and information on best practices and exemplary programs must be conveyed to the right stakeholders, parent advocates, and policymakers.

Federal, state, and local lawmakers are elected to represent the views of their constituents. In the absence of hearing what their constituents need, believe, and hope, officials operate on the basis of what they know or what others tell them. While there is an expectation that elected officials will be enlightened and influenced by fact, sometimes this is not the case. Citizens have both a right and an obligation to be sure that elected officials have accurate data. What is really happening in schools and communities? As professionals whose work is based in those schools and communities, educators know better than do most politicians working in the state or nation's capitol. Moreover, as advocates for children, and as professionals dedicated to improving the lives and education of children, it is unconscionable to allow elected officials to continue to operate under misperceptions and/or misguided opinions.

School mental health professionals know what works for students. They have spent years in practice and in the study of effective practices and replication of exemplary programs for prevention and intervention. Sometimes they are so entrenched in the practice that they assume the importance of prevention and intervention efforts are common understanding. In reality, however, most policymakers and stakeholders in educational reform are either unaware of these beliefs or do not understand the role of school mental health professionals and their ability to help students reach educational objectives.

Most policymakers, even those directly involved with the education system, do not understand the effective and wide range of services that school mental health professionals can provide to help children reach world-class standards and reduce the risk of dangerous behavior. How can we rectify this gap in knowledge and influence? How can educators become more involved in restructuring and reform to make sure that children's social, emotional, and learning needs are met? And how can educators make sure that policymakers understand the value of integrating mental health services into the restructured school?

Conclusion

Both opportunities and dangers lie ahead for future legislation promoting crisis intervention and needed mental health services. Many school mental health professionals are concerned that not enough is being done to promote these services at the local, state, or federal level. However, each individual can make a difference. By reaching out to members of Congress and officials involved in state and local education, mental health, and justice, school mental health professionals and educators can provide our elected officials with factual information and realistic feedback on important topics.

At the very least, participation in professional association advocacy efforts to promote crisis intervention and mental health services will sharpen the skills needed to be more active at the state and local level. Learning that something is happening on a topic in Washington, DC, might inspire local debate. By taking some of the simple steps outlined by networks such as SPAN, education advocates can model the activities of local and state association members and other interested colleagues to advance effective local policies. For additional information on becoming an effective advocate, refer to the this chapter's Appendix.

References

Adelman, H., & Taylor L. (2000). *Addressing barriers to learning* (Vol. 5, No. 4). Los Angeles, CA: School Mental Health Project, Center for Mental Health in Schools.

American School Health Association. (1999). *School health in America* (6th ed.). Kent, OH: Author.

Bennett, D., & Fielding, P. (1999). *The net effect: How cyberadvocacy is changing the political landscape*. Merrifield, VA: e-advocates Press.

Center for Mental Health Services. (1996a). *An update on human resources in mental health. Mental Health, United States, 1996*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Center for Mental Health Services. (1996b). *Prevalence of serious emotional disturbance in children and adolescents. Mental Health, United States, 1996*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Centers for Disease Control. (1999). *The Surgeon General's call to action to prevent suicide*. Available Online: www.surgeongeneral.gov

Centers for Disease Control. (2001). *Youth violence: A report of the Surgeon General*. Available Online: www.surgeongeneral.gov.

Children's Health Act. PL 106-310, § 3, 114 Stat. 1101 (2000).

Dwyer, K. P. (1995). Government Relations. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 91-100). Washington, DC: National Association of School Psychologists.

Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide*. Washington, DC: U.S. Departments of Education and Justice, American Institutes of Research.

Dwyer K., Osher D., & Warger, C. (1998) *Early warning timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education.

Hodgkinson, H. (1995, April). *What demographers can tell us about special education*. Keynote address to the Office of Special Education and Related Services Leadership Conference. Washington, DC.

Individuals with Disabilities Education Act of 1997, PL 105-17, § 1, 111 Stat. 37 (1997).

Institute of Medicine. (1997). *Schools and health*. Washington, DC: National Academy Press.

Juvenile Justice and Delinquency Prevention Act of 1974, 42 U.S.C. § 5601 (1974).

Larson, K. A. (1995). *Redefining troublemakers*. Speech at Office of Special Education Training Conference, Washington, DC.

National Education Association. (2000, January 18). *Top concerns for Washington to address*. (Public opinion poll). Washington, DC: Author.

National Center for Education Statistics. (1998). *Violence and discipline problems in U.S. public schools: 1996-97* (No. 98-030). Washington, DC: U.S. Department of Education.

Reauthorization of the Elementary and Secondary Education Act of 1965: Hearing before the Committee on Health, Education, Labor, and Pensions, Senate. 106th Cong., 2nd Sess. (1999) (testimony of Richard W. Riley).

Senate Rep. No. 166, 106 Cong., 2nd Sess. (1999). 6.

U.S. Public Health Service. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda.* Washington, DC: Author.

U.S. Department of Education, Office of Elementary and Secondary Education. (1999). *The Educational Excellence for All Children Act of 1999, Legislation and section-by-section analysis.* Washington, DC: Author.

U.S. Department of Education, Office of Special Education and Rehabilitative Services. (1999, March 12). *IDEA'97 Amendments, Final Regulations: Assistance to States for the Education of Children With Disabilities and the Early Intervention Program for Infants and Toddlers With Disabilities.* Washington, DC: Author. Available Online: www.ed.gov/offices/OSERS/IDEA/

U.S. Department of Health and Human Services and U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda.* Available Online: www.surgeongeneral.gov

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (1999). *Safe futures: A partnership to reduce youth violence and delinquency.* Washington, DC: Author.

Wagner, M. (1991). *Youth with disabilities: How are they doing? The National Longitudinal Transition Study of Special Education Students.* Menlo Park CA: SRI International.

Wilgoren, J. (2000, February, 16). Poll finds education is chief concern of likely voters. *The New York Times*, p. A23.

Appendix

Becoming an Effective Advocate for School-Based Mental Health Services

1. Consult the NASP Advocacy Action Center, *www.nasponline.org/advocacy*, to learn about your federal or state senators and representatives. Review facts about them, including which district (schools) they may represent, political affiliation, committee assignments, personal history, special interest areas, such as involvement in education, and staff names.

2. Send your legislators messages through the NASP Advocacy Action Center to let them know that we need their support and that you would like to be involved in the legislative process. Offer to be a local resource person if the legislator has questions about your area of knowledge. Legislators like to know professionals they can call on regarding specific issues.

3. Meet with your legislators at their local offices. You may team with other colleagues and pupil services personnel. If legislators are newly elected, congratulate them. If the legislator is unavailable, meet with staff. Use their names and keep in touch throughout the legislative session to remind them of our issues and ask about progress. Leave a note or materials summarizing your mission. Be sure to leave your name and address.

4. Rehearse a one-sentence description of your mission: "I am a school psychologist in your district, and I would like to discuss some concerns I have about school safety." Bring summary information to leave for them and a copy for yourself to stay on topic. You may choose to make a brief outline of the points you wish to convey. Be prepared to relate at least one quick real-life example illustrating how critical appropriate psychological services are to educational success.

5. Write a follow-up letter thanking the legislator and/or staff for time spent on your issue and include a brief summary of your visit. Assure the legislator that you will stay in touch. Touch base throughout the legislative session to remind them of our issues and ask about progress.

6. Invite legislators, in collaboration with other school personnel, to visit your school(s). Legislators are invited to hundreds of events a month so you must do something special to get them to attend. Make your invitations personal. Be determined to include them. During the visit, be sure they learn more about what you do and how students benefit. Include your school district staff on invitations and events.

7. Directly ask legislators if they would be willing to support a specific proposal, vote yes (or no) for a certain bill or amendment, or champion an issue. Offer to be a local resource person if the legislator has questions about education issues. You have to ask in order to get assistance or a commitment.

8. A polite, positive approach is always best. If the legislator says something with which you disagree, practice good active listening skills and politely offer facts (if you have them) to rebut the statement. After you leave you may think of a point or find relevant information to support your argument. This presents a perfect opportunity to follow up with the office and restate your point. The more they hear from you, the more you will make the issues known. Expect that you will need to follow up. Sometimes it takes years to correct faulty information and it may require having the legislator visit some of your schools.

9. Make note of any contacts you, your family, or friends may have with legislators or staff. Remember that local school board members, city and county officials, and other local leaders as well as local political party officials often have strong connections to legislators.

Note
Contact legislators on your own time (*not during your scheduled workday*). Use *personal stationary* rather than *letterhead* if you are not speaking as an *official representative* of that organization. Remember that your address as a voting constituent is more important than a specific title you may hold. Reprinted from Florida Association of School Psychologists materials, Kay Young, 1999

36

Research Needs for School Crisis Prevention Programs

危機

Michael P. Bates, Ph.D.
Michael J. Furlong, Ph.D.
Jill D. Saxton, M. Ed.
Renee Pavelski, M. Ed.
University of California, Santa Barbara

The recent increase in public concern about school safety (Langdon & Vesper, 2000) has renewed interest in responding to and taking steps to prevent crises involving violence on school campuses. Involvement in school violence-prevention efforts has become central to the role of school mental health professionals (Cheramie & Sutter, 1993), prompting Larson, Smith, and Furlong (in press) to propose a set of standard competencies to ensure that school psychologists are adequately trained to address these issues. In addition, the state of California, as part of its school psychology credential standards, has recently outlined a set of training objectives for school safety planning, including best practices in school safety prevention programming (California Commission on Teacher Credentialing, 2000).

Along with heightened interest in violence prevention has come a concomitant emphasis on implementing interventions that are empirically supported (Kazdin & Weisz, 1998). Stoiber and Kratochwill (2000), in their discussion of empirically supported interventions for school psychology, highlighted a number of pressing research needs in the field, including: (a) more precisely defining the groups of students who receive prevention services; (b) moving from general terms (e.g., *emotional and behavioral problems*) to more specific terms (*aggressive behaviors*) when evaluating program effectivenesss; and (c) ultimately matching intervention components to specific targeted groups to determine "what works for whom" (Smith, Larson, DeBaryshe, & Salzman, 2000).

Given these developments and needs, it is important to review what is known about school violence prevention and become aware of the issues surrounding its empirical study. Whereas the other chapters in this volume suggest best practices for implementing crisis response and prevention in schools, the purpose of this chapter is to stimulate thought about the issues school mental health professionals should consider when designing, implementing, and evaluating crisis prevention programs. Given space considerations, we limit our discussion to crises involving interpersonal violence committed against others, rather than including other types of crisis events such as suicide and natural disasters; however, we believe that these considerations are instructive for these other crises as well.

Current Status of School Violence Prevention

The overall news about the effectiveness of preventative interventions for children and adolescents is positive. Meta-analyses of primary (Durlak & Wells, 1997) and secondary (Durlak & Wells, 1998) mental health prevention programs in multiple settings show that they are typically effective, with mean effect sizes (ESs) in the 0.50s for secondary prevention and ranging from 0.24 to 0.93 for primary prevention. Put another way, the average participant in both types of programs tended to surpass the performance of 60-80% of the participants in control groups. These are generally considered to be moderate to large effects. These results suggest that preventative interventions are as efficacious as psychotherapy and may be more effective at addressing problem behaviors such as substance use and delinquency, which tend to be associated with violence (Durlak & Wells, 1998).

In a third meta-analytic study focusing specifically on school violence-prevention programs, Derzon, Wilson, and Cunningham (2000) found similar results. Each of the studies they reviewed were school-based prevention or intervention programs either (a) targeting students at risk for violent behavior or (b) with the specific aim to reduce violence and antisocial behaviors at school. In general, programs successfully reduced antisocial behaviors (ESs from -0.130 to 0.442), although the results were mixed for more overt forms of violent behavior. For example, programs targeting fighting and physical violence demonstrated positive effects (i.e., reduced fighting and violence), yet there were no effects for the two programs targeting weapon carrying on campus, and negative effects were shown for programs targeting both violence and an array of other antisocial behaviors. (Surprisingly, there have been *only two* empirical intervention studies addressing weapon carrying on school campuses.)

The results of these meta-analysis reviews generate some tentative conclusions about the effectiveness of prevention programming, but they also highlight some important shortcomings in this research. Derzon et al. (2000) identified 584 independent studies evaluating school-based, violence-prevention efforts. Of these, only 174 contained quantitative data that allowed for summarization of any sort and *only 82 contained sufficient data to enable effect sizes to be calculated* and thus be included in the meta-analysis. Consequently, the understanding of violence prevention in schools, based on meta-analytic techniques, is limited to a relatively small proportion of the studies available and demonstrates the difficulties facing practitioners who are admonished to use "research-based" prevention programs. Derzon et al. (2000) also expressed concern that a majority of these 82 studies that contained quantitative data amenable to the meta-analysis focused on nonviolent antisocial behaviors (e.g., substance use, suspensions) or nonantisocial behaviors (e.g., knowledge, attitudes, peer relations) as outcomes to demonstrate the effectiveness of "violence prevention." *Only five of these studies reviewed used clear, unambiguous measures of physical violence* (e.g., "behavioral data on violent interpersonal behavior," p. 25). Thus, empirical research provides some information about short-term outcomes, but there is insufficient information to know precisely how these prevention programs might help reduce violence over the long term. In addition, despite the general public's concern about tragic school shootings, there is no research examining efforts to prevent more extreme acts of violence on school campuses, likely due to the rarity of these events and the difficulty of conducting such research.

The focus on nonviolent outcomes (e.g., disruptive behavior, poor social skills, substance use, attitudes toward aggression) in prevention research implies a theoretical model of violence at school in which these proximal outcomes mediate the occurrence of school violence; yet this implied theory is rarely meaningfully evaluated in prevention research. Designers of school violence-prevention programs rarely test the linkages between these mediator variables and the ultimate outcome—interpersonal violence.

> … [M]any of the antisocial outcomes that are serving as proxy variables for violence are, potentially, only modestly related to violence. One can readily imagine reasons for suspension that have little or nothing to do with the display of violent behavior, and being "aggressively inclined" or sharing characteristics with those who have aggressed should not be mistaken for actually acting violent. (Derzon et al., 2000, p. 32)

The lack of such evidence represents a clear need for research in this area and suggests that future programs target more specific and overt forms of violence to demonstrate effectiveness.

The review and meta-analytic studies discussed in this chapter represent significant contributions to the field, but there is still a need to refine knowledge of school violence prevention. The ultimate goal should be to understand which types of programs and which program components are most effective with which types of students. To achieve this level of precision will require a greater understanding of the processes involved in the nature of violence and antisocial behavior that occurs on school campuses.

Many scholars have contributed to the understanding of the development of youth violence in the broader community context (see Loeber & Farrington, 1998), yet there are relatively few theories of the development of youth violence specific to the school context. Morrison, Furlong, and Morrison (1994, 1997), for example, have proposed that violence at school is not the same as violence in the community because of the special relationships that characterize the bonds between students and teachers. School violence ought to be considered a risk factor in and of itself that is more akin to exposure to family violence than to other types of community violence (Furlong, Morrison, Chung, Bates, & Morrison, 1997). As such, school violence prevention should be thought of as a distinct subset of violence-prevention programs for youths, and researchers in this area need to consider conditions and contexts on school campuses that contribute to violent events.

Most violence-prevention programs appear to be guided by practical rather than theoretical principles. To improve our understanding, we need theory-driven intervention models that provide a framework to systematically test, modify, and guide future developments. These models are needed to identify and understand the factors that enhance implementation, maintenance, and generalization of program objectives. It is also necessary to integrate theories of violence to better understand how the processes and conditions of school facilitate or discourage the occurrence of violence. By focusing attention on these theories, the stage is set to examine how progress can be made in studying the effectiveness of prevention programming. With this backdrop, the remainder of this chapter addresses some of the fundamental obstacles that prevent a clearer understanding of school violence prevention and then discusses some critical issues that tend to be neglected in studies examining school violence.

School Violence Research Barriers

There are a number of technical and theoretical obstacles to performing research on school violence-prevention efforts. Although a literature of prevention studies is beginning to be compiled, it is clear that more well-controlled studies of prevention programs are needed to better understand which intervention components are most effective for which students. Until now, however, researchers have largely ignored a number of fundamental issues that act as barriers to a fuller understanding of school violence-prevention efforts.

Definition and Target

Perhaps the most fundamental of these issues is a lack of consensus about the definition of school violence. The way in which school violence is defined dictates the way in which it is prevented and treated. In addition, a clear definition is necessary to facilitate the comparison of various studies. Various conceptualizations of school violence have ranged from defining it as criminal activity or physical harm [e.g., "the use or credible threat of use of physical force intended to physically harm other persons or property" (Elliott, Hamburg, & Williams, 1998, p. 21)] to broader definitions incorporating acts and conditions that contribute to physical, psychological, and developmental harm (Furlong & Morrison, 2000; Furlong, Morrison, & Pavelski, 2000). A public health or medical model tends to view school violence as a "disease" needing a "cure" (School violence, 1999), whereas a juvenile justice perspective views school violence as relating to crime and drugs—both implying that the individual student should be the target of intervention. The School Effectiveness model (Furlong et al., 1997; Furlong, Pavelski, & Saxton, 2002) views school violence as both a by-product and cause of ineffective schools that negatively impacts the development, achievement, and potential of students. Thus, school violence is viewed within a developmental framework as a risk factor that encompasses a subset of all types of potential harm that occur on school campuses (Morrison et al., 1994). This model implies that environmental (e.g., school climate) and relational (e.g., teacher and peer bonding) factors should also be targets of intervention, in addition to individual factors. We suggest that prevention programs incorporate a definition of school violence that addresses a broad range of individual, peer, family, school, classroom, and community risk factors, or, at a minimum, clearly identifies the target of intervention within a grounding of theoretical support.

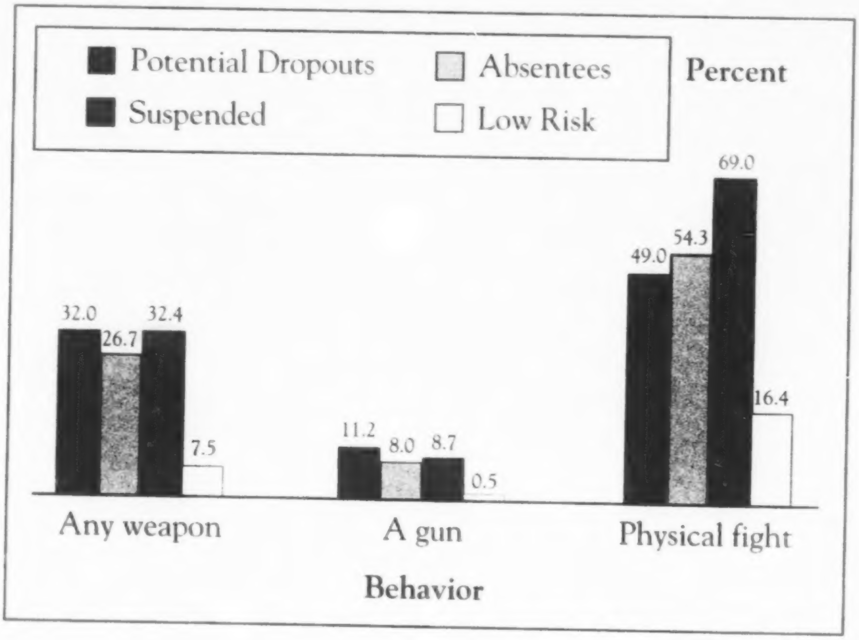
Measurement

Behaviors and risk. To design better prevention programs, researchers need to have a clearer idea about the prevalence and patterns of the violent events that occur on school campuses. Traditionally, knowledge of school violence has come from large-scale surveys of nationally representative samples of junior and senior high school students such as the National Crime Victimization Survey (Chandler, Chapman, Rand, & Taylor, 1998) and the Youth Risk Behavior Surveillance Survey (YRBS; e.g., Brener, Simon, Krug, & Lowry, 1999). These surveys have usually taken an epidemiological approach, estimating the prevalence of violence and other high-risk behaviors using frequencies of responses to single items (e.g., "carried a weapon to school in the past 30 days") from representative samples of the general school population. This approach is limited in that it fails to generate useful information about which students are most likely to engage most frequently in these violent behaviors and in which other behaviors these students might be engaged.

Using the 1997 YRBS, Furlong, Sharma, and Rhee (2000) found that victimization at school is common among secondary school students. One-third of females and one-half of males reported at least one of four types of victimization in a typical school month, and only a relatively small number (between 0.5% and 1.0% across grades 9 to 12) reported experiencing all four types. To extend this analysis and to illustrate a potentially more promising approach, these authors analyzed responses from more than 6,000 students from a representative sample of California high school students to the California Student Survey (Austin, Huh-Kim, Skager, & Furlong, 2000), which uses items based on the YRBS. Responses were examined according to three types of school adjustment problems: truancy, disciplinary suspensions, and those considering dropping out of school. As illustrated in Figure 1, on page 760, when compared with low-risk students, students with school adjustment problems were much more likely to report that they engaged in fights, weapon possession, and gun possession on their school campuses. Given the presence of this relatively small, high-risk group of students, the results of this study emphasize the importance of precisely defining the link between prevention programs and the needs of differing group of students. Current policy mandates for using "research-based" prevention and intervention programs have not adequately taken into consideration the wide disparities of violence-related behaviors at school by subgroups of high-risk youths.

Figure 1

Percentage of students reporting that they engaged in selected violence-related behaviors (physical fight in past 12 months, carried a weapon or gun to school in past 30 days) on their school campus, by school adjustment risk characteristics (potential dropout, absentee, suspended). This study was conducted using a sample of 3,669 9th- and 11th-grade students from throughout California, reporting none (low-risk, n = 3,055), one (n = 844), two (n = 334), or three (n = 68) school adjustment risk factors. Adapted from Austin, Huh-Kim, Skager, and Furlong (2000).



Item wordings. Particularly on national surveys of violence on school campuses, there is variation across instruments in wording of items that inquire about events. As an illustration, the YRBS inquires about weapon possession on school campuses using the following item: "In the past 30 days on how many days did you carry a weapon (knife, gun, club) on school property?" This item influences public policy by claiming to measure the population base rate of weapon possession on school campuses. From a measurement perspective, however, this item is ambiguous and imprecise. Among some of the complications of interpreting responses to this item is the fact that, literally, *the past 30 days* includes school and nonschool days. Of course, the public and policy makers typically interpret this item to assess weapon possession on school campuses when classes are in session. In addition, the term "weapon" is not defined for the respondent. It is conceivable that a student might have brought a knife to school in the past 30 days without the intention of potentially using it as a weapon (e.g., by accident, to butter their bread). It is unknown how students interpret such circumstances and how they influence responses to this item. Our fundamental point is that researchers should carefully evaluate all school violence-related data and their sources and critically evaluate all survey instruments regardless of their prevalence of use.

Time frames. There is also inconsistency across scales in the referent time periods to which students are asked to respond (e.g., past 30 days, past 6 months, past year). This presents a serious problem because rates of school violence are often extrapolated in both the popular and empirical literature (i.e., "a child is victimized at school every 28 seconds"). In a study specifically addressing the validity of time frames, Hilton, Harris, and Rice (1998) found no differences in self-reported rates of violence victimization whether subjects were asked to reference the preceding 6- or 12-month period, raising serious questions about the accuracy of extrapolations and students' recall over such long time periods. Unfortunately, it is unclear which time frames make the most sense in terms of school-focused surveys. Does "the past 12 months" provide a more meaningful context than, say, "the past school year?" These issues, rarely addressed by researchers, clearly have substantial implications for understanding school violence prevalence and patterns.

Response validity. Rates of violent events tend to be inflated by the failure to carefully screen surveys for inconsistent or invalid responses. Several studies (Cornell & Loper, 1998; Rosenblatt & Furlong, 1997) have demonstrated that students who endorse similar items in inconsistent ways (e.g., "I always feel safe at school" and "I never feel safe at school") and/or who give responses with questionable validity (e.g., obvious response sets, failure to complete items, extreme responses to most or all items in a set) reported significantly higher rates of violence-related behaviors. Cornell and Loper (1998), for example, found that 50% of 7th-, 9th-, and 11th-graders who failed any one of eight validity checks reported that they had carried a gun for protection at school. When these invalid responses were eliminated from the sample, the overall gun-carrying rate *dropped from 18.4% to 7.7%*. Given that such single-item frequency statistics predominate in government policy reports (e.g., U.S. Departments of Education and Justice, 1999), it is imperative that national school-violence surveys address the issue of inconsistent and invalid responses.

Predictive validity. In recent years the widespread focus on serious incidents of violence on school campuses has been accompanied by a push to develop methods to identify potentially violent youths. Although essentially no research has evaluated the direct benefit or the indirect unintended consequences of screening procedures to identify potentially violent students, a body of research is emerging that identifies risk factors for extreme forms of violence by students on school campuses (e.g., Bear, Webster-Stratton, Furlong, & Rhee, 2000; Verlinden, Hersen, & Thomas, 2000). This literature has the potential to positively influence school mental health practice by expanding or enhancing knowledge about the broad range of risk factors associated with aggressive behavior. It may also encourage school counseling and school psychology as professions to more fully embrace the importance of systematically providing (and evaluating) prevention services for students who engage in antisocial behaviors at school. Nonetheless, as suggested by Dwyer, Osher, and Warger (1998), there is a need for a continuum of screening efforts directed toward aggressive behavior that enable early identification and response. As public pressure for early identification of aggressive behavior patterns among students increases, researchers will need to evaluate carefully the effectiveness of such efforts to take into consideration their potential unintended impacts on the school community.

Program Design

Description. A number of elements related to program design should be included in studies of prevention programs. Perhaps the most important charge is to describe the intervention clearly and completely, or make materials available, so that others can replicate the intervention. A number of critical conditions should be mandatory requirements for study publication, including descriptions of (a) characteristics of students receiving the treatment; (b) the treatment provided, including number and length of sessions; (c) characteristics of treatment providers; (d) conditions under which treatment was provided; and (e) any other special or unusual factors. Although this may seem straightforward, Smith et al. (2000) reported, in a review of anger management programs, that most failed to provide information about who actually administered the treatments. To refine knowledge, a high level of precision is needed to determine the factors contributing to a given program's success or failure.

Treatment fidelity. As with all intervention studies, it is important to record the degree to which the treatment components were administered faithfully. Such evidence is necessary to establish the internal validity of the study and to conclude that any observed changes were attributable to treatment effects.

Longitudinal designs. Researchers need to understand the long-term effects of violence-prevention efforts by analyzing patterns of violence in the same setting over multiple years. A similar approach for youth violence in multiple community settings (see Loeber & Farrington, 1998) has provided insight into the developmental trajectories of youths involved in violence and delinquency. A similar approach specific to schools is needed to better understand school violence.

Maintenance and generalization. Smith et al. (2000) stressed the importance of inoculation and generalization components in helping to maintain the short-term gains of prevention programs. They highlighted the work of Lochman and his colleagues (e.g., Lochman, Lampron, Gemmer, Harris, & Wyckoff, 1989) as an example of best practices toward this end. Lochman et al. addressed these issues by systematically testing different maintenance models to determine how best to ensure long-term positive changes in students receiving their anger management program. Our understanding of school violence prevention would benefit from the implementation of this research model.

Analysis

To some extent, knowledge of school violence has been limited by the analytic approaches used by researchers. A shift in analytic strategies is needed to explore more closely national school safety survey data by (a) examining the full range of responses to single items to identify the most high-risk students (i.e., those students with the most serious and/or chronic patterns of violent behaviors); (b) crossing multiple items to obtain a clearer picture of the relations between violence behaviors among the highest risk groups; and (c) examining relationships between item responses and key student characteristics, such as gender, ethnicity, and risk status, for other outcomes such as academic failure and dropout. Given the limitations of relying on single items, a critical step is to incorporate multiple-item scales with demonstrated reliability into large-scale national surveys.

Neglected Issues in Prevention Research

In this section, we briefly address several issues that are important in understanding the development of violent behaviors among youths yet have been largely neglected in research on the origins of violence at school.

Gender Differences

Almost all of the research into the nature and prevention of violence has focused on males. Although violence is still committed more often by boys than girls, rates of violence have been increasing much faster for girls (Artz, 1998). Poe-Yamagata and Butts (1996) reported that in 1993, an estimated 570,100 arrests in the United States involved female juveniles, an increase of 23% from 1989 (versus an 11% increase for males). Though in its infancy, research investigating females' developmental pathways to violence from early childhood into adolescence indicates that girls have a more discontinuous pattern of disturbance than do boys. Girls tend to demonstrate a variety of temperamental difficulties in infancy and behavioral problems in toddlerhood, a decline or lack of increase in overall behavioral and emotional problems in childhood, and then an increase in anxiety and depression during adolescence and adulthood (Keenan & Shaw, 1997). By contrast, boys seem to develop emotional and behavioral problems in a more linear fashion, with more serious behavioral problems following less disruptive problems (Kelley, Loeber, Keenan, & DeLamatre, 1997). Furthermore, boys are significantly more likely to use physical aggression, such as hitting or kicking (Schwartz et al., 1998), whereas girls are significantly more likely to use relational aggression, such as excluding a friend or revealing sensitive gossip (Crick et al., 1999). To design effective prevention programs for this often overlooked population, we need to understand more fully (a) the factors that contribute to the development of girls' violent behavior and (b) the ways that girls express violence.

Dating Violence

Between 1992 and 2000, 33 school-associated violent deaths involved romantic relationships, usually taking the form of (a) murder of a perceived or actual rival or (b) murder-suicide typically involving nonstudent adults [National School Safety Center (NSSC), 2000]. The prevalence of dating violence and sexual harassment on school campuses is well-documented (Furlong, Chung, Bates, & Morrison, 1995; NSSC, 2000), yet little attention is paid to these topics in the prevention literature. It has been shown that students' attitudes and beliefs related to dating violence are differentially linked to the probability that they will engage in violent acts. In one study (Bennett & Fineran, 1998), both male and female adolescents who held the belief that men should be in control of relationships were more likely to use violence in their own lives. A second study (Gagne & Lavoie, 1993) provided evidence that both male and female adolescents tend to (a) view female-initiated violence as justified (either through provocation or self-defense); (b) view male-initiated violence as an indication of power (domination and intimidation); (c) minimize males' responsibility for violence (caused by substance use, behavior problems, influence of friends, losing control of anger); and (d) view jealous violence as a positive sign of love. This research suggests that adolescents' beliefs and attitudes about violence within romantic relationships may contribute to a cultural norm whereby violence is viewed as an acceptable, even favorable, course of action. Thus, efforts to understand youth violence within the school context must also incorporate both (a) information about the violence norms, beliefs, and attitudes to which students subscribe and (b) an understanding of the dynamics of teens' interpersonal and romantic relationships.

Hate-Based Violence

Ethnic-racial violence. Research suggests that student experiences of violent and aggressive behavior at school vary somewhat by their racial/ethnic identification (Brener et al., 1999), but large differences in student experiences across racial/ethnic groups have not been found (Kingery, Biafora, & Zimmerman, 1996). Studies have shown that African-American students report slightly higher rates and Hispanic students report slightly lower rates of violence victimization both nationally (Chandler et al., 1998; O'Keefe & Sela-Amit, 1997) and in California (Furlong, Morrison, Bates, & Chung, 1998). Another study (Shapiro, Dorman, Welker, & Clough, 1998) found that African Americans had a greater acceptance and usage of guns and violence. Data on racial and ethnic differences must be analyzed with caution because few studies are available on the topic. Yet these findings suggest that intervention developers need to consider factors such as ethnicity, subgroup, country of origin, and immigration status, as well as sex, age, and socioeconomic status when designing violence-prevention programs (Kingery et al., 1996).

Gay/lesbian/bisexual violence. Studies of gay/lesbian/bisexual (GLB) youths in school reveal that they experience a significantly higher frequency of verbal harassment and physical assault than their heterosexual peers (Besner & Spungin, 1995; Harbeck, 1992; Herek & Berrill, 1992; Ryan & Futterman, 1998). Nearly half of the GLB youths in these studies experienced property damage by other youths, and approximately one-third were threatened or injured with a weapon on school grounds or involved in a physical fight with classmates. In response to threats of attacks, a small but significant proportion of GLB youths reported carrying a weapon to school for self-defense or skipping school because of safety concerns. Further studies suggest that the primary offenders in these fights are young men who endorse a masculinist ideology and whose peers oppose homosexuality. Particularly intriguing is the finding that a sizable proportion of individuals who engage in physical confrontations with homosexuals perceive their actions as self-defense (Franklin, 2000). It appears that violence against GLB youths represents a distinct subtype of school violence that is only recently coming to the attention of school personnel. In addition to better documenting and understanding the violence-related experiences of GLB students, school researchers will need to evaluate violence-prevention efforts as they pertain to the unique experiences and needs of GLB students.

Classroom Behaviors

A final obvious, but often overlooked, focus of school-violence research is to better understand and evaluate how classroom disciplinary practices contribute to or inhibit aggressive behavior. In this regard, there is a need to understand the day-to-day experiences of students who may be at risk of being a perpetrator or victim of school violence. For example, one point of investigation would be to examine the interactions between teachers and students in the classroom, particularly the behavioral sequences (including potential setting events) leading to aggressive and violent acts. Several recent studies use observational and social interaction sequencing techniques to profile the interactions of teachers and students with emotional and behavioral disorders (EBD; Shores & Wehby, 1999). Developing a better understanding of these interactions will shed light on the social context of students with EBD and may help to understand the causal factors behind some types of aggressive and violent behaviors at school.

Conclusion

In this chapter, we discussed some of the barriers to conducting research on the prevention of school violence and highlighted some of the issues that we believe need more attention. Despite a fairly sizable number of studies, we still don't have a clear understanding of which prevention programs are most effective for which students. Although there are many challenges in school violence-prevention research, we can reframe this as an opportunity to influence how school mental health professionals can contribute to fill the gaps in our knowledge. One implication of the recent move toward accountability and empirically supported treatments is that educators are increasingly called upon to implement "research-based" programs that have been "proven" effective. Yet, no programs have been proven to be effective across a range of settings with a variety of populations, and none have been validated for the diverse violence-prevention needs of students. Even programs with empirical support may not be appropriate for a particular school with a particular student population and a particular intervention need (e.g., to reduce fighting on school grounds).

Our intent is not to apply pressure on school practitioners to conduct empirical "research," but rather to encourage educators to monitor the conditions on their campuses, think critically about what outcomes they wish to achieve for which students, and choose established intervention elements and/or design sound theory-based elements that match their individualized needs. By attending to these critical issues, schools can begin to evaluate their prevention efforts systematically and better understand their needs. Incorporating these evaluation techniques into everyday practice can have numerous benefits, such as providing justification for continued support of prevention programs, increasing the prospect of extra funding, providing feedback to modify or eliminate ineffective programs, and, ultimately, documenting (and disseminating information about) successful efforts that improve outcomes for students, teachers, and schools.

References

Artz, S. (1998). *Sex, power, and the violent school girl*. New York: Teachers College Press.

Austin, G., Huh-Kim, J., Skager, R., & Furlong, M. (2000). *Violence and safety among California students: Results from the 1997-98 California Student Survey*. Sacramento, CA: California Office of the Attorney General.

Bear, G., Webster-Stratton, C., Furlong, M. J., & Rhee, S. (2000). Prevention of school violence. In K. Minke & G. Bear (Eds.), *Preventing school problems—Promoting school success: Strategies that work* (pp. 1-69). Bethesda, MD: National Association of School Psychologists.

Bennett, L., & Fineran, S. (1998). Sexual and severe physical violence among high school students: Power beliefs, gender, and relationship. *American Journal of Orthopsychiatry*, *68*, 645-652.

Besner, H., & Spungin, C. (1995). *Gay and lesbian students: Understanding their needs*. Washington, DC: Taylor & Francis.

Brener, N. D., Simon, T. R., Krug, E. G., & Lowry, R. (1999). Recent trends in violence-related behaviors among high school students in the United States. *Journal of the American Medical Association*, *282*, 440-446.

California Commission on Teacher Credentialing. (2000). *Standards for training pupil personnel specialists*. Sacramento, CA: Author.

Chandler, K. A., Chapman, C. D., Rand, M. R., & Taylor, B. M. (1998). *Students' reports of school crime: 1989 and 1995* (NCES 98-241/NCJ-169607). Washington, DC: U.S. Departments of Education and Justice.

Cheramie, G. M., & Sutter, E. G. (1993). Role expansion in school psychology: The need for primary and secondary prevention services. *Psychology in the Schools*, *30*, 53-59.

Cornell, D. G., & Loper, A. B. (1998). Assessment of violence and other high-risk behaviors with a school survey. *School Psychology Review*, *27*, 317-330.

Crick, N. R., Werner, N. E., Casas, J. F., O'Brien, K. M., Nelson, D. A., Grotpeter, J. K., & Markon, K. (1999). Childhood aggression and gender: A new look at an old problem. In D. Bernstein (Ed.), *Nebraska symposium on motivation: Vol. 45. Gender and motivation* (pp. 75-141). Lincoln, NE: University of Nebraska Press.

Derzon, J. H., Wilson, S. J., & Cunningham, C. A. (2000). *The effectiveness of school-based interventions for preventing and reducing violence*. Unpublished manuscript.

Durlak, J. A., & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology*, *25*, 115-152.

Durlak, J. A., & Wells, A. M. (1998). Evaluation of indicated preventive intervention (secondary prevention) mental health programs for children and adolescents. *American Journal of Community Psychology*, *26*, 775-802.

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U.S. Department of Education.

Elliott, D. S., Hamburg, B. A., & Williams, K. R. (1998). *Violence in American schools: A new perspective*. New York: Cambridge University Press.

Franklin, K. (2000). Antigay behaviors among young adults: Prevalence, patterns, and motivators in a noncriminal population. *Journal of Interpersonal Violence*, *15*, 339-362.

Furlong, M. J., Chung, A., Bates, M., & Morrison, R. (1995). Who are the victims of school violence? *Education and Treatment of Children*, *18*, 282-298.

Furlong, M. J., & Morrison, G. M. (2000). The SCHOOL in school violence: Definitions and facts. *Journal of Emotional & Behavioral Disorders*, *8*, 71-82.

Furlong, M. J., Morrison, G. M., Chung, A., Bates, M., & Morrison, R. (1997). School violence. In G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems, and alternatives* (pp. 245-256). Bethesda, MD: National Association of School Psychologists.

Furlong, M. J., Morrison, G. M., & Pavelski, R. (2000). Trends in school psychology for the 21st century: Influences of school violence on professional change. *Psychology in the Schools*, *37*, 81-90.

Furlong, M., J., Morrison, R., Bates, M., & Chung, A. (1998). School violence victimization among secondary students in California: Grade, gender, and racial-ethnic group incidence patterns. *California School Psychologist*, *3*, 71-87.

Furlong, M. J., Pavelski, R., & Saxton, J. (2002). The prevention of school violence. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (pp. 131-150). Bethesda, MD: National Association of School Psychologists.

Furlong, M. J., Sharma, B., & Rhee, S. (2000). Defining school violence victim subtypes: A step toward adapting prevention and intervention programs to match student needs. In D. S. Sandhu & C. Aspy (Eds.), *Violence in American schools: A practical guide for counselors* (pp. 67-87). Reston, VA: American Counseling Association.

Gagne, M. H., & Lavoie, F. (1993, Fall). Young people's views on the causes of violence in adolescents' romantic relationships. *Canada's Mental Health*, *41*, 11-15.

Harbeck, K. (Ed.). (1992). *Coming out of the classroom closet: Gay and lesbian students, teachers, and curricula*. New York: Harrington Press.

Herek, G., & Berrill, K. (Eds.). (1992). *Hate crimes: Confronting violence against lesbians and gay men*. Thousand Oaks, CA: Sage.

Hilton, N. Z., Harris, G. T., & Rice, M. E. (1998). On the validity of self-reported rates of interpersonal violence. *Journal of International Violence*, *13*, 58-72.

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66, 19-36.

Keenan, K., & Shaw, D. (1997). Developmental and social influences on young girls' early problem behavior. *Psychological Bulletin*, *121*, 95-113.

Kelley, B. T., Loeber, R., Keenan, K., & DeLamatre, M. (1997, December). Developmental pathways in boys' disruptive and delinquent behavior. *Juvenile Justice Bulletin*, 1-20. Available Online:
www.ncjrs.org/html/ojjdp/jjbul9712-2/jjb1297.html

Kingery, P. M., Biafora, F. A., & Zimmerman, R. S. (1996). Risk factors for violent behaviors among ethnically diverse urban adolescents: Beyond race/ethnicity. *School Psychology International*, *17*, 171-188.

Langdon, C. A., & Vesper, N. (2000). The Sixth Phi Delta Kappa Poll of Teacher's Attitudes Toward the Public Schools. *Phi Delta Kappan*, *81*, 607-611.

Larson, J., Smith, D., & Furlong, M. J. (in press). Best practices in school violence prevention. In A. Thomas (Ed.), *Best practices in school psychology IV*. Bethesda, MD: National Association of School Psychologists.

Lochman, J. E., Lampron, L. B., Gemmer, T. C., Harris, S. R., & Wyckoff, G. M. (1989). Teacher consultation and cognitive-behavioral interventions with aggressive boys. *Psychology in the Schools*, *26*, 179-187.

Loeber, R., & Farrington, D. P. (Eds.). (1998). *Serious and violent juvenile offenders: Risk factors and successful interventions*. Thousand Oaks, CA: Sage.

Morrison, G. M., Furlong, M. J., & Morrison, R. L. (1994). From school violence to school safety: Reframing the problem for school psychologists. *School Psychology Review*, *23*, 236-256.

Morrison, G. M., Furlong, M. J., & Morrison, R. L. (1997). The safe school: Moving beyond crime prevention to school empowerment. In A. P. Goldstein & J. C. Conoley (Eds.), *School violence intervention: A practical handbook* (pp. 236-264). New York: Guilford Press.

National School Safety Center. (2000). *School associated violent deaths*. Thousand Oaks, CA: Author. [Report]. Available Online: www.nssc1.org/savd/savd.pdf

O'Keefe, M., & Sela-Amit, M. (1997). An examination of the effects of race/ethnicity and social class on adolescents' exposure to violence. *Journal of Social Service Research*, *22*, 53-71.

Poe-Yamagata, E., & Butts, J. A. (1996). *Female offenders in the juvenile justice system: Statistics summary*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Rosenblatt, J., & Furlong, M. J. (1997). Assessing the reliability and validity of student self reports of campus violence. *Journal of Youth & Adolescence*, *26*, 187-202.

Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.

School violence: Protecting our children: Hearing before the subcommittee on Early Childhood, Youth, and Families, 106th Cong., 1st Sess. (1999) (Testimony of Mark L. Rosenberg). Available Online: www.house.gov/ed_workforce/hearings/106th/ecyf/schviolence31199/wl31199.htm

Schwartz, D., Dodge, K. A., Coie, J. D., Hubbard, J. A., Cillessen, A. H., Lemeuse, E. A., & Bateman, H. (1998). Social-cognitive and behavioral correlates of aggression and victimization in boys' play groups. *Journal of Abnormal Child Psychology*, *26*, 431-440.

Shapiro, J. P., Dorman, R. L., Welker, C. J., & Clough, J. B. (1998). Youth attitudes toward guns and violence: Relations with sex, age, ethnic group, and firearm exposure. *Journal of Child Clinical Psychology*, *27*, 98-108.

Shores, R. E., & Wehby, J. H. (1999). Analyzing the classroom social behavior of students with EBD. *Journal of Emotional and Behavioral Disorders*, *7*, 194-199.

Smith, D. C., Larson, J., DeBaryshe B., & Salzman, M. (2000). Anger management for youth: What works and for whom? In D. S. Sandhu & C. Aspy (Eds.), *Violence in American schools: A practical guide for counselors* (pp. 217-230). Reston, VA: American Counseling Association.

Stoiber, K. C., & Kratochwill, T. R. (2000). Empirically supported interventions and school psychology: Rationale and methodological issues – Part I. *School Psychology Quarterly, 15*, 75-105.

U.S. Departments of Education and Justice. (1999). *Annual report on school safety.* Washington, DC: Authors. Available Online: www.ed.gov/pubs/edpubs.html

Verlinden, S., Hersen, M., & Thomas, J. (2000). Risk factors in school shootings. *Clinical Psychology Review, 20*, 3-56.

37

危機

Research and Evaluation Directions in Crisis Intervention

Pauline M. Pagliocca, Ph.D.
Amanda B. Nickerson, M.A.
Stephanie H. Williams, M.A.
University of South Carolina

In the opening chapter of this volume, Brock describes the field of school crisis response as a maturing one. In the development of any field, there comes a time to stop and reflect and to examine our progress before choosing future directions. The existing literature on responding to school crises suggests that we have not yet taken the opportunity to examine and assess our work. Perhaps we have been too busy responding to schools in need; or perhaps we have been reluctant to employ a critical eye, for fear of what we might see. An even greater possibility is that, until recently, we did not have sufficient knowledge and skill to look critically at the field's evolving framework for understanding and responding to schools in crisis.

We believe that we have matured to a point where we can now afford to look carefully and critically at the field of school crisis response, to identify promising practices, and to use our assessment to guide the future. This chapter provides an overview of existing research related to schools' response to traumatic events in order to stimulate thinking about ways to gauge current effectiveness and develop a framework for future, ongoing assessment of our work.

The State of Research and Evaluation in School Crisis Response

The Call for Evaluation

For more than two decades, researchers and practitioners have called for the evaluation of crisis intervention programs and strategies (e.g., Auerbach & Kilmann, 1977; Slaikeu, 1990). For example, Auerbach (1983) noted the need for research to describe operationally what actually takes place between counselor and client in crisis counseling and to assess popular assumptions about the natural course of crisis resolution, the identification of individuals in crisis, and the optimal timing of intervention. Vernberg and Vogel (1993) cited the limited evaluation of child-focused interventions following natural disasters and noted the need for systematic assessment of practices that have been described in case reports and widely adopted by practitioners. Slaikeu (1990), too, noted an overreliance on case reports, relative to systematic research, in the crisis literature, generally.

More recently has come a call for research and evaluation of crisis intervention as it has developed in schools (e.g., Brock, Sandoval, & Lewis, 1996; Klingman, 1996; Nelson & Slaikeu, 1990). Vernberg (1994) cited the lack of systematic evaluation of school-based interventions that rely, instead, on primarily descriptive accounts of specific incidents. Likewise, Slaikeu (1990) cautioned against the proliferation of "how to" crisis intervention publications. Also citing the overreliance on descriptive case reports, Nelson and Slaikeu (1990) suggested that schools use their design for service development and implementation as a guide in evaluating those same crisis intervention programs. Their proposal would fit with Brock et al.'s (1996) recommendation that evaluation become a formal component of every school district's policy for responding to crises. Despite the proliferation of crisis management teams and programs, few school districts have undertaken the task of evaluating their efforts.

Basic Research on Children and Trauma

Despite a growing body of research describing children's reactions to a range of traumatic events (for reviews, see, e.g., DiNicola, 1996; Fletcher, 1996; Horn & Trickett, 1998; Mazza & Overstreet, 2000; Putnam, 1996a; Pynoos, Steinberg, & Goenjian, 1996), this area of research is still quite limited (Fletcher, 1996; Putnam, 1996b). Nevertheless, existing findings on children's reactions to crises can be instructive as we consider how research and evaluation might be conducted for the benefit of the schools as service providers. For example, knowledge of the typical range, severity, and duration of symptoms has implications for the types, levels, and extent of services that might be needed in a given crisis situation. Such information can be incorporated into plans for evaluating a school's readiness to respond to a range of traumatic events. A critical question to ask is whether we are looking to basic research about children and adults to guide our response efforts and, in turn, our evaluation of such responses.

Because several chapters in this volume describe in detail children's reactions to traumatic events, we will not repeat that information here. Three points directly relevant to this discussion of the need for research and evaluation, however, are worthy of attention. First, although children's reactions are generally similar to those of adults, they do not always match an adult picture of posttraumatic stress disorder (PTSD), but instead frequently appear in forms more familiar to many school practitioners. For example, some children are more likely to exhibit aggressive, depressive, regressive, or generally anxious behavior (Fletcher, 1996; Mazza & Overstreet, 2000; Putnam, 1996a, 1996b). Second, with children, a developmental perspective is necessary because symptoms may vary with age and because a coping strategy successful at one stage of development may prove maladaptive at another (Belter & Shannon, 1993; Fletcher, 1996; Putnam, 1996b). Third, despite a growing interest in ethnocultural aspects of children's development, there is a significant lack of research related to traumatic experience and relevant treatment (DiNicola, 1996). Given these issues, schools will need to consider a range of psychological and behavioral reactions in planning for and evaluating the effectiveness of intervention.

Evaluation and Intervention Research

Comprehensive Program Evaluation

In one of the earliest published descriptions of comprehensive, multi-faceted, school-based crisis services, Klingman and Ben Eli (1981) commented, "Work pressure has not permitted us to carry out a thorough and well-controlled survey" (p. 531). Whether due to work pressure or other reasons, few surveys or other methods of evaluation have been reported since they provided their detailed proposal for responding to emergencies affecting schools. Recently, the Task Force on Model Programs in Service Delivery[1] identified Klingman's model as an exemplary program (Roberts, 1996). Still, 20 years later, he noted the as yet unmet challenge of replicable research in school crisis response (Klingman, 1996). Although some *components* of Klingman's crisis management program have been evaluated, the model as a whole has not.

A preponderance of the school crisis literature consists of various types of case studies. Guba and Lincoln (1981) and Yin (1994) have identified a number of purposes of case studies, ranging from recording events as they happened to explaining the causal links between interventions and their outcomes. Most school crisis case studies fall into two categories: (a) those that *describe* or *chronicle* a particular violent or otherwise traumatic event (e.g., a shooting on school grounds or a natural disaster) and the steps taken in the immediate aftermath; and (b) those that *teach* about planning and intervention strategies, on a more general level. The 1990s brought a proliferation of what might be categorized as "teaching" case studies or "how to" manuals for developing school crisis response teams and plans (e.g., Brock et al., 1996; Klingman, 1993; Nelson & Slaikeu, 1990; Petersen & Straub, 1992; Pitcher & Poland, 1992; Poland & McCormick, 1999). We are not aware, however, of any published reports that might be categorized as comprehensive *evaluation* case studies that *test* hypotheses or *explain* causal links between program implementation and program effects. Conducting program-level research and evaluation of crisis response is a challenging task, given the unpredictability of many traumatic events, concern for victims' welfare, and the logistics of field research (see Smith, 1996). Nonetheless, as Klingman (1996) suggests, this task still awaits us.

Specific Intervention Components

Although the field suffers from a scarcity of published evaluations of comprehensive crisis response programs, attempts have been made to assess the effectiveness of individual program components. Before describing specific intervention strategies that have undergone field evaluation, however, we first turn to a brief exploration of some commonly recommended practices in the school crisis field and the assumptions on which they are based.

Common Assumptions in Crisis Intervention Practice

Many elements of school crisis plans appear to be founded on assumptions common to the more general crisis intervention field. Whereas some assumptions have been submitted to scrutiny, others have not, but have gained general acceptance and strongly influence practice. Although many common practices have only scant empirical evidence of their effectiveness with children, often they are based on "plausible conceptual assumptions" and have gained consensus across theoretical perspectives (Vernberg & Vogel, 1993, p. 485). Drawing primarily on the commentaries of Auerbach (1983) and Vernberg and Vogel (1993), this section briefly discusses a limited number of assumptions and practices, recognizing that some represent "favorite" strategies in the field. We do not intend to discourage their use or suggest that they have been found ineffective; but we do want to highlight the need for more rigorous investigation of their advisability in school practice. The assumptions are posed below as questions, suggesting areas for future research and evaluation.

Is there an optimal time to provide treatment? A common assumption in the crisis field is that for optimal effectiveness, treatment must occur as soon as possible after a traumatic event (e.g., Gillis, 1993; Klingman, 1993; Pynoos & Nader, 1988). Various explanations for this belief and resulting practices have been offered, including: (a) individuals in crisis are highly suggestible and motivated following a crisis (discussed by Auerbach, 1983); and (b) children are highly susceptible to developing cognitive distortions and other maladaptive defense mechanisms that affect memory and interfere with recovery (e.g., Gillis, 1993; Nader & Pynoos, 1993). Related to immediacy is the assumption that the school, itself, is a recommended site for treatment. Like the immediacy assumption, the "close to the scene" assumption appears to stem primarily from early thinking about soldiers in combat and the desire to treat them in the field and return them to battle as quickly as possible. While limited support may exist for such an approach with combat soldiers (see, e.g., Herman, 1997), the extrapolation to school children, including those traumatized at school, may not be warranted. Worthy of further research however, is the belief in the benefits of social support provided by familiar adults in a familiar setting (Auerbach & Spirito, 1986; Klingman, 1993) and the value of resuming an active, familiar role following a disruptive, traumatic event (Vernberg, 1999).

Do children and adults benefit from debriefing and other group interventions? The trauma and disaster literature is replete with testimonies to the use and benefits of "critical incident stress debriefing," developed by Mitchell for use with emergency response workers (Mitchell, 1983; Mitchell & Everly, 1995). Debriefing may be one of the best examples of a strategy that has enjoyed wholesale adoption by a host of crisis intervention providers, including schools. Although some organizations (e.g., American Red Cross, National Organization of Victim Assistance) and school crisis practitioners (e.g., Brock, 1998; Johnson, 1998; Juhnke, 1997) have modified this group intervention somewhat, neither the original nor its variations have, until recently, been subjected to critical examination. In the past few years, research findings have suggested that debriefing may not be as effective as had been assumed and, in some cases, has even found to be harmful (for further discussion, see Avery, King, Bretherton, & Orner, 1999; Mitchell & Everly, 1998; Rose & Bisson, 1998). A body of research that supports debriefing approaches with children, parents, and school personnel has yet to be developed.

Several writers in the school crisis field have advocated small-group and classroom counseling, citing the opportunity to develop or strengthen support systems (e.g., Nader & Pynoos, 1993; Young, Ford, Ruzek, Friedman, & Gusman, 1999) and identify children in need of individual attention (e.g., Gillis, 1993; Weinberg, 1990). While a few specific descriptions for such groups have been circulated—such as Auerbach and Spirito's (1986) stress inoculation approach and Galante and Foa's (1986) structured group treatment of elementary students following an earthquake—most accounts provide little detail about treatment procedures. An early criticism, based on an extensive review of the crisis literature (Auerbach & Kilmann, 1977; Auerbach, 1983), that most accounts fail to specify what crisis therapists actually do in treatment, may still apply today to both group and individual crisis counseling. Assessment of additional components of group treatment with children, including the size, composition, and timing, is also needed.

Does successful adaptation require direct exploration of the trauma? Many individual and group interventions operate on the premise that the traumatic event, as well as children's reactions and feelings, must be directly addressed in treatment to ensure successful coping. Indeed, the original debriefing model identifies specific stages for addressing these various points. Although most crisis practitioners (e.g., Brock, 1998; Poland & McCormick, 1999; Pynoos & Nader, 1988) advocate giving children an opportunity to discuss their experience and express their feelings (through talk or other media), not all subscribe to the necessity of direct exploration (e.g., Terr, 1989; van der Kolk, McFarlane, & van der Hart, 1996). Most reports on this issue are anecdotal, and little research with children has been undertaken regarding the need to confront traumatic material directly (Vernberg & Vogel, 1993). Relevant here are the same questions raised above regarding the ability to document treatment techniques, as well as the question of the qualifications of school clinicians who undertake more confrontative, direct approaches, whether they be behavioral, cognitive, or psychodynamic in orientation.

Do memorials and other rituals facilitate recovery? Society has generally established formal rituals and ceremonies to commemorate significant events, including death and disasters. In an early study of a school's coping with death, memorials involving children were associated with better recovery (Keith & Ellis, 1978), but research on the therapeutic value of such practices is scant. The use of rituals and memorials has been advocated in the crisis literature (e.g., Arena, Hermann, & Hoffman, 1984; Pynoos & Nader, 1988), but with considerable caution, and even prohibition, being suggested in the case of suicide (see Poland, 1997, for a discussion of conflicting recommendations regarding suicide). Study of the value and role of various types of commemorations and other rituals carried out by schools is needed.

Do written informational fact sheets facilitate adaptation? "Fact sheets" and other educational materials describing children's and adults' trauma reactions and helpful strategies for parents, teachers, and other caregivers have become widely available. A quick trip on the Internet to the websites of various professional and governmental organizations yields multiple examples of what Klingman (1993) has termed "biblioguidance." While the information across such sources appears relatively consistent, the degree of accuracy of the "facts" distributed in the aftermath of school crises is largely unknown. Likewise, whether informational handouts and brochures are actually used, lead to effective interventions by the targeted caregivers, or contribute to positive coping remains unexamined (Vernberg & Vogel, 1993).

Are crisis drills an effective strategy for preparing students and staff for real emergencies? For at least a decade, crisis drills have been endorsed as a necessary component of response preparedness (e.g., Poland & Pitcher, 1990). Such drills have become increasingly popular, as perceptions of the dangers in schools have heightened. While advocates have cited the need for students and staff to practice quick response to emergencies, critics have argued two conflicting points: (a) crisis drills are an overreaction that may actually decrease students' sense of safety and increase perceptions of threat, and (b) mock-crisis drills may contribute to nonchalance in the face of a real emergency (e.g., Grech, 1999). Critics also cite the potential for revealing escape routes and other security information to would-be attackers. Some suggest that, although crisis and disaster drills may be useful training exercises for school and community responders, student involvement should be limited because of the potential for inducing fear (e.g., Grech, 1999; International Association of Chiefs of Police, 1999; State of Missouri School Crisis Plan, 1999). A series of studies by R. Jones and colleagues, demonstrating the effectiveness of behavioral training strategies to develop fire emergency skills, however, may hold relevance for other school emergencies (e.g., Hillman, Jones, & Farmer, 1986; Jones, Ollendick, McLaughlin, & Williams, 1989). Although mock-disaster drills are routine in the emergency services sector, they have not been studied sufficiently in school settings. Thus, their role in contributing to the physical safety and/or psychological preparedness of the school community is not yet understood.

The intervention practices cited above represent some of the most popular in the school crisis field. Auerbach and Spirito's (1998) comment on a similar range of strategies used with children and families following disasters, that "These suggestions have face validity, but from the most rigorous standpoint they should be considered hypotheses [sic] that await validation through systematic research" (p. 201) is applicable to these and other approaches currently in use in schools. We now turn to a sampling of school-based crisis intervention strategies that have been submitted to field investigation. Each of these suggests evaluation strategies that might be employed by school districts seeking to develop more rigorous evaluation of their crisis response programs.

Research Support for School Crisis Intervention Practices

Although a systematic body of research examining the effectiveness of crisis intervention in schools has yet to be developed, several evaluative efforts have been made. Effectiveness studies can generally be classified into one of two categories: (a) direct interventions with children, or (b) multi-level interventions involving children and the significant adults in their lives.

Direct interventions with children. A primary goal of most posttrauma classroom interventions is to elicit children's feelings and reactions in an effort to foster appropriate expression and increase tolerance for anxiety (Klingman, 1993). Relevant techniques that have been examined include narratives, story telling, and open discussion (Blom, 1986; Galante & Foa, 1986; Keith & Ellis, 1978; Pynoos, Goenjian, & Steinberg, 1998); drawings or other forms of artwork (Blom, 1986; Galante & Foa, 1986; Schwarz, 1982); and free writing (Klingman, 1985).

Keith and Ellis (1978) conducted a descriptive, naturalistic study of the response of school personnel and students to the death of a classmate or teacher. Based on written summaries of the school's handling of the deaths, and interviews with children, teachers, and counselors, they found that educators either dealt with death directly or completely ignored it. In classrooms where teachers dealt with the death directly—by telling the class what had happened, allowing for discussion, and guiding group decision making about actions to take (including planning memorials)—children coped better. In contrast, in classrooms where teachers ignored the death—by abruptly removing the child's belongings and not discussing the death—children showed multiple signs of maladaptive coping.

Schwarz (1982) also studied the effects of direct intervention in schools. In an Israeli village attacked by rockets, the art teacher worked with elementary school children daily for a three-week period, using multiple drawing and writing techniques to encourage children's release of emotional tension. Analysis of more than 300 pieces of artwork from before and after the war revealed that postwar drawings contained themes of painful, yet effective, coping. Schwarz attributed the children's ability to maintain a sense of security to two factors: (a) the support of adults (parents, teachers, counselors) and children in the village, and (b) the art-related activities, which encouraged the children to express their emotions in an environment over which adults maintained a confident sense of control. Although these conclusions may be intuitively appealing, the lack of a comparison group makes it difficult to assess the effectiveness of this intervention.

In one of the few reported controlled studies, Klingman (1985) examined the effects of a preventive program in which fifth- and sixth-grade Israeli children were taught to express their thoughts and feelings through free writing. Twelve classrooms were randomly assigned to either the experimental or control condition, with the experimental classroom teachers and students attending writing workshops. Nearly three months later, the town was shelled during the night, and the teachers led the children through free-writing exercises the following day. Trained judges found that the writing of children in the experimental groups contained more personal information and greater expression of stress and other feelings both postworkshop and after the shelling, as compared with baseline, whereas these effects were not found for the control groups. Because free writing was conceptualized as being therapeutic due to its ability, in part, to release tension and express feelings, the results of this study may be considered supportive of its effectiveness. Future studies using this intervention technique should focus on accurate measuring of functioning and symptomatology (e.g., PTSD) in evaluating its effectiveness as a preventive strategy in helping children cope with stressful events.

Following a devastating earthquake, Galante and Foa (1986) implemented a year-long intervention with children in Italy. At monthly intervals, children in one affected school attended a week-long series of group sessions, discussing fears, mistaken beliefs, feelings about the earthquake and death, and emphasizing the future and the children as active survivors. Techniques included drawings, discussion, stories, role-playing, funeral rituals, and the teaching of survival skills. Treated children showed a reduction in fears and risk scores following the intervention, but this effect was not found for those children who had experienced a death in their family. In another village, where children did not receive treatment but still did well, it was found that the community had effective support systems and a principal who gathered students together to express their feelings. It was concluded that children's resilience was positively related to the availability of a family support system; the reestablishment of their daily routine, including school; and the provision of a structured opportunity to discuss and work through their fears.

Multiple-level interventions involving significant adults. It has been well documented that children's reactions to traumatic situations are largely affected by the responses of their parents and other adults (Auerbach & Spirito, 1986; Belter & Shannon, 1993; Bolin, 1988; Danto, 1978a; Doll & Lyon, 1998), leading to the assertion that work with parents and educators is a critical part of effective crisis intervention (e.g., Cohen, 1988; Glasser, 1978). A few notable efforts have been made to document the effectiveness of this work following school crises.

In an early account of school crisis response, Danto (1978a) wrote a detailed, descriptive case study of the intervention strategies used when a first-grade teacher was shot and killed in her classroom. A multidisciplinary team—consisting of the superintendent, psychologist, social worker, supervising educational psychologist, and outside consultant—met with the parents of the affected children. Five monthly meetings with parents were held in which the team presented facts about the event, the investigation, and the court proceedings; answered questions; and advised parents about expected reactions and helpful ways to assist their children. It was observed that the parents' level of coping largely influenced their children's level of coping, with more anxious parents having children who had more difficulty. Peer support was also found to facilitate children's coping. Danto concluded that school staff and others skilled in crisis intervention should work directly with parents, emphasizing the importance of role modeling.

Danto's evaluative case study was followed by a series of critical commentaries from educators and mental health professionals (Ack, 1978; Glasser, 1978; McComb, 1978; Mihalik, 1978; Rappeport, 1978; Schmuck, 1978; Stanford, 1978). Danto then provided a response to their critiques (Danto, 1978b). This series of papers provided an opportunity for readers to "listen in" on an alternative form of peer review, one that might be considered in future reports relying on case study techniques.

Perhaps the most well-established, comprehensive model for postdisaster mental health intervention in schools is that developed by Pynoos and colleagues at the UCLA Trauma Psychiatry Program (Pynoos, Goenjian, & Steinberg, 1998). This "public mental health approach" involves the execution of a well-organized governmental response, which mobilizes public, private, and volunteer resources. A major component of the UCLA model includes selecting, planning, and organizing teams for assessment, triage, and intervention. Another major ingredient involves debriefing members of the school community, such as administrators, teachers, support staff, parents, and children, with particular attention to the needs of the principal and those most personally affected by the experience. The model addresses the needs of individuals, groups, families, and the community, with five treatment foci: (1) traumatic experiences, (2) traumatic reminders, (3) bereavement, (4) post-disaster stresses, and (5) developmental impact. Supplemental components, addressing community violence, recently have been developed for parents, teachers, and police officers. (For a detailed description, see Pynoos et al., 1998, and the references contained therein.)

The UCLA model has been implemented in multiple settings as it has evolved over several years, and evaluation results are beginning to be published. For example, in a controlled treatment outcome study following a major earthquake in Armenia, Pynoos et al. (1998) found no differences in the control and treatment groups' PTSD scores one and a half years after the intervention. Three years later, however, significant differences were found, with the treatment group having lower PTSD scores than the nontreated group, whose symptoms worsened. Although depression scores for the treated group remained unchanged, the untreated group's scores worsened over time. These findings suggest that the comprehensive model may assist in the long-term recovery from disaster and protect children from developing psychological disturbance over time.

Conclusions Regarding the State of Research and Evaluation

This sampling of assumptions, practices, and evaluation strategies in the school crisis field suggests some conclusions that can be instructive in future efforts to assess the direction of the field, as well as the response capacity of individual schools and districts. First, the need for research and evaluation in the crisis field has been noted for more than 20 years, but has only recently garnered attention in the *school* crisis field. Second, as school crisis teams have proliferated, many practices have been based on assumptions, often without the benefit of careful investigation. Third, the limited number of efforts that have been made to evaluate components of school crisis programs should be commended.

As a cautionary statement, it is essential to consider that only recently have controlled studies begun to be conducted. Early studies have been primarily descriptive and often based on anecdotal reports of trauma survivors or crisis interveners, with little objective observation or data collection. One important consideration in weighing the value of such reports is the state of individuals in crisis at a time when they may be highly suggestible and likely to view virtually any intervention as helpful (Caplan, 1964; Halpern, 1973; Taplin, 1971). A second and related consideration is the personal investment of crisis interveners. In an early account of emergency organizational consultation, Babad and Salomon (1978) cautioned psychologists against confusing "personal acceptance" with "professional effectiveness," suggesting that acceptance may sometimes "indicate their success as *people* but not necessarily their professional impact" (p. 845). They add that, "A client's expressed satisfaction may serve to prevent the psychologist from a more critical evaluation" (p. 845). More optimistically, however, Babad and Salomon also describe the possibility of emergency consultants or interveners perceiving failure where success has not yet become apparent, a "sleeper effect," in which positive outcome becomes more evident at a later time.

Whether from trauma victims or crisis interveners, such anecdotal reports and testimonials must be supported by systematic research and evaluation, including follow-up evaluation, before we can draw firm conclusions about the effectiveness of current approaches to school crisis intervention. With this summary of the state of the field, we now turn our focus more directly to the future incorporation of evaluation into school crisis response programs.

Focus on Evaluation: Looking to the Future

Over the past decade, the school crisis field has begun to develop its own identity, but we need not work in isolation in developing, implementing, or evaluating response programs. Much can be learned from the broader trauma and disaster fields of which we have become a part. Many of the lessons learned from these fields are addressed throughout this volume. In this section, we turn to the appraisal of school crisis practice and review some of the challenges and opportunities involved. It is assumed here that evaluation is not an afterthought, but rather an essential component of every crisis program, beginning with the initial stages of conception and continuing over the life of the program (Brock et al., 1996). Although we focus primarily on mental health interventions, the issues, questions, and suggestions presented can be extended to crisis response components focusing more directly on physical safety and security; indeed, the two are often inextricably linked.

Evaluation: Challenge and Opportunity

In 1964, Caplan advocated the incorporation of research and evaluation in the development of community preventive mental health programs. His advice is relevant to school crisis response programs more than a quarter of a century later.

> It is ... important to build into every community program a research component to focus attention on the evaluation of the effects of various services and methods ... many of our methods are not based on the firm ground of tested hypotheses, and it is therefore all the more important to keep a constant objective check on their effectiveness in order to discard as quickly as possible those which do not achieve their goals. (pp. 161-162)

In addition, conducting ongoing, systematic evaluation offers an opportunity to identify and disseminate effective and promising practices.

Methodological and Ethical Challenges

Although we stress the importance of conducting research and evaluation, we would be remiss if we did not acknowledge the methodological and ethical challenges that crisis research poses. For example, although control is a hallmark of traditional research design, it is nearly impossible to achieve in most school crises; thus, quasi-experimental and evaluation research designs may be more feasible (see e.g., Cook & Campbell, 1979; Rossi, Freeman, & Lipsey, 1999). Such approaches may be tailored to the setting and involve evaluators, practitioners, and clients in program planning and evaluation (e.g., Wandersman, Imm, Chinman, & Kaftarian, 1999, 2000). Another methodological challenge involves assessing the high degree of variability in behavioral and emotional responses to, and recovery from, traumatic experience (Galante & Foa, 1987; Harvey, 1996; Sandoval, 1987). Another important assessment issue is the identification and measurement of outcome criteria in the face of two conflicting hypotheses: (a) that crises resolve themselves with or without intervention (e.g., Caplan, 1964; Harvey, 1996; Schwartz, 1971), in contrast to (b) that, without treatment, symptoms worsen over time (e.g., Bolton, O'Ryan, Udwin, Boyle, & Yule, 2000; Pynoos et al., 1998; Yule et al., 2000). From a more practical perspective, Vernberg's (1994) experience following Hurricane Hugo suggests that researchers must also plan for two significant barriers: (a) gaining approval and access from school administration and research review boards and (b) securing funding to undertake crisis intervention research. Although such factors must be considered in any proposed school-based research, in the absence of prior planning they may present a greater challenge in the face of violence or disaster. These methodological and practical issues serve as illustrations of factors to consider in planning for evaluation of school crisis intervention.

In addition to methodological issues, trauma researchers (e.g., Armstrong, 1996; Newman, Kaloupek, Keane, & Folstein, 1997; Putnam, 1996b) describe a range of ethical considerations in conducting research with traumatized individuals and settings. Although all emphasize an obligation to demonstrate concern for the well-being and privacy of individuals and their capacity to provide truly informed consent, Newman et al. (1997) also note the lack of research evidence about the psychological risks involved in participating in trauma-related research. Likewise, they note the absence of data regarding the potential psychological benefits from such participation. Like the school crisis field itself, far more research is needed before we can draw conclusions about the risks and benefits of crisis research involvement.

Clearly, evaluating the impact of large-scale events and related response efforts can be challenging for school personnel and experienced researchers, alike. Terms such as "research" and "evaluation" may conjure up images of complex research designs that sometimes fail to capture the essence of an intervention and its impact. However, by actively joining the research effort, we have an opportunity to enhance the positive impact of responding to school-related trauma. Here we attend to evaluation that can be carried out by school personnel—and researchers—in school settings, primarily for the benefit of the school itself. Much like the crisis field more generally, however, program evaluation has not evolved to a point that warrants a prescriptive set of strategies. Thus, we advocate for an "evaluation mindset," one that is cognizant of the current state of school crisis research, and yet optimistic about its future.

Guiding Questions

As one step in developing a mindset open to critique and evaluation, we propose a set of "guiding questions" about school crisis plans and practices. These questions—and their answers—can be considered repeatedly when developing and reviewing policies:

- What are the assumptions—or the theoretical or empirical foundation—upon which the plan/strategy is based?
- What is the intended purpose or outcome?
- Are the components in place?

- How will we know that the intervention has been implemented as planned?
- How will we know if we have accomplished the purpose?

Answers to questions such as these are critical to consider at this developmental stage of the school crisis field, when any number of published manuals and school district policies can be adopted almost wholesale, with little attention to the rationale for doing so. While guiding questions may be a good starting point in establishing an evaluation mindset, we must also consider an array of strategies for finding answers.

Ways of Knowing

In describing an ecological approach to program evaluation, Tharp and Gallimore (1979) discuss four "ways of knowing" that can be incorporated into assessing the benefits of a crisis response program and its components. Through these four approaches—or ways of knowing—Tharp and Gallimore provide a framework for thinking creatively and flexibly about evaluation strategies to answer the guiding questions posed above, as well as to meet other program and policy demands.

Experimentation. This approach includes traditional, controlled experiments and quasi-experiments that test individual elements of a program. This approach assesses the contribution of individual elements but not their relationship to each other or the program as a whole. Examples of school crisis evaluation discussed above tend to fit this category. Schools sometimes find it more acceptable to create comparison groups, rather than experimental or no-treatment control groups, for assessing the effectiveness of specific interventions. Another variation, which can minimize the challenge of assessing large numbers of children, involves targeting high-risk children (using research-based criteria for identification) for intervention and assessment.

Program evaluation. Although similar to the experimentation approach, program evaluation compares total program effects with "other-than-program" effects (Tharp & Gallimore, 1979, p. 47), in essence, a larger-scale experiment. The program must be consistent and stable in order to use this approach. At this point, the crisis literature contains few studies in this category. Because individual crisis plans may not be ready to undergo this level of evaluation, we recommend a combination of the other "ways" described here in moving the program toward more comprehensive analysis. It seems unlikely that multiple programs will reach a level of stability for cross-program comparisons in the near future; as such, the other ways of knowing may be more promising as starting points for evaluation.

Personal knowing and qualitative methods. This last "way of knowing" ranges from "unsystematic intuitions" to "systematic ethnographies," with all techniques relying on observation of the setting, as is, without manipulation. As described by Tharp and Gallimore (1979), "In its highest form it is wisdom, in its lowest, delusion" (p. 48).

The limited number of research reports of school interventions often involves qualitative data and methods, including interviewing, descriptive reporting, drawing, writing, and other curriculum-related assessments. When these are used in schools, they can serve as true data, subject to analysis as rigorous as any quantitative measure.

Data guidance. Comparable to "formative evaluation," a term more familiar to many program evaluators (Scriven, 1967), data guidance is recommended for programs still in development. This approach relies on frequent and continuous monitoring of objectives, with feedback used to modify objectives and/or strategies. Although specific corrections for discrepancies between objectives and actual performance will not necessarily be identified through this iterative approach, effective strategies are likely to be developed. The evaluative case study, using both quantitative and qualitative methods, is one strategy that may fit this category. Rigorous case studies rely on multiple sources and types of data, and do not stop at mere description (see Yin, 1994, for an introduction to case study methods). Given the state of school crisis response, we recommend that all four ways of knowing be subsumed under "data guidance" that contributes to the evolution of the program, including the elimination of elements that fail to show promise.

Concluding Remarks

In this chapter, we attempted to address the state of the art and science of school crisis response, a field still in development. As is evident, much is still to be learned about effective intervention for schools affected by violence, disasters, and other traumatic events. While we can—and should—look to the broader trauma, violence, and disaster fields for guidance, school crisis clinicians and researchers must also contribute to the knowledge base that guides our work. While it may not be feasible for schools to conduct large-scale basic research related to trauma and crisis, there is much we can do to inform the field.

As this review suggests, research in school crisis response is scant. Although many of our interventions have a strong theoretical and/or conceptual base, it is our responsibility to demonstrate empirical support as well. To accomplish this, we urge practitioners and researchers to work collaboratively to make evaluation a priority in program development and implementation. In addition, we strongly advocate disseminating evaluation findings so they become a component of data guidance for the field as a whole and, thus, contribute to the psychosocial well-being of all members of the school community.

References

Ack, M. (1978). Time delays change intervention process. *The School Counselor, 26*, 91-93.

Arena, C., Hermann, J., & Hoffman, T. (1984). Helping children deal with the death of a classmate: A crisis intervention model. *Elementary School Guidance and Counseling, 19*, 107-115.

Armstrong, J. G. (1996). Emotional issues and ethical aspects of trauma research. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 174-187). Lutherville, MD: Sidran.

Auerbach, S. M. (1983). Crisis intervention research: Methodological considerations and some recent findings. In L. H. Cohen, W. L. Claiborn, & G. A. Specter (Eds.), *Crisis intervention* (2nd ed., pp. 191-211). New York: Human Sciences.

Auerbach, S. M., & Kilmann, P. R. (1977). Crisis intervention: A review of outcome research. *Psychological Bulletin, 84*, 1189-1217.

Auerbach, S. M., & Spirito, A. (1986). Crisis intervention with children exposed to natural disasters. In S. M. Auerbach, & A. L. Stolberg (Eds.), *Crisis intervention with children and families* (pp. 191-202). Washington, DC: Hemisphere Publishing.

Avery, A., King, S., Bretherton, R., & Orner, R. (1999, Fall). Deconstructing psychological debriefing and the emergence of calls for evidence-based practice. *Traumatic StressPoints*, pp. 6-8.

Babad, E. Y., & Salomon, G. (1978). Professional dilemmas of the psychologist in an organizational emergency. *American Psychologist, 33*, 840-846.

Belter, R. W., & Shannon, M. P. (1993). Impact of natural disasters on children and families. In C. F. Saylor (Ed.), *Children and disasters* (pp. 85-103). New York: Plenum.

Blom, G. E. (1986). A school disaster—Intervention and research aspects. *Journal of the American Academy of Child Psychiatry, 25*, 336-345.

Bolin, R. (1988). Response to natural disasters. In M. Lystad (Ed.), *Mental health response to mass emergencies: Theory and practice* (pp. 22-51). New York: Brunner/Mazel.

Bolton, D., O'Ryan, D., Udwin, O., Boyle, S., & Yule, W. (2000). The long-term psychological effects of a disaster experienced in adolescence: II: General Psychopathology. *Journal of Child Psychology and Psychiatry, 41*, 513-523.

Brock, S. E. (1998). Helping classrooms cope with traumatic events. *Professional School Counseling, 2*, 111-116.

Brock, S. E., Sandoval, J., & Lewis, S. (1996). *Preparing for crises in the schools: A manual for building school crisis response teams*. Brandon, VT: Clinical Psychology Publishing Company.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Cohen, R. E. (1988). Intervention programs for children. In M. Lystad (Ed.), *Mental health response to mass emergencies: Theory and practice* (pp. 262-283). New York: Brunner/Mazel.

Cook, T. C., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings*. Boston: Houghton Mifflin.

Danto, B. L. (1978a). Crisis intervention in a classroom regarding the homicide of a teacher. *The School Counselor, 26*, 69-89.

Danto, B. L. (1978b). Danto responds ... *The School Counselor, 26*, 101-102.

DiNicola, V. F. (1996). Ethnocultural aspects of PTSD and related disorders among children and adolescents. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 389-414). Washington, DC: American Psychological Association.

Doll, B., & Lyon, M. A. (1998). Risk and resilience: Implications for the delivery of educational and mental health services in schools. *School Psychology Review, 27*, 348-363.

Fletcher, K. E. (1996). Childhood posttraumatic stress disorder. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 242-276). New York: Guilford Press.

Galante, R., & Foa, D. (1986). An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. *Journal of the American Academy of Child Psychiatry, 25*, 357-363.

Gillis, H. M. (1993). Individual and small-group psychotherapy for children involved in trauma and disaster. In C. F. Saylor (Ed.), *Children and disasters* (pp. 165-186). New York: Plenum.

Glasser, W. (1978). Parent anxiety adds to fears. *The School Counselor, 26*, 90-91.

Grech, D. A. (1999, September 13). Security drills, or scares? School crisis plans make some uneasy. *The Washington Post*, p. 01.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco: Jossey-Bass.

Halpern, H. A. (1973). Crisis theory: A definitional study. *Community Mental Health Journal, 9*, 342-349.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*, 3-23.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York: Basic Books.

Hillman, H. S., Jones, R. T., & Farmer, L. (1986). The acquisition and maintenance of fire emergency skills: Effects of rationale and behavioral practice. *Journal of Pediatric Psychology, 11*, 247-258.

Horn, J. L., & Trickett, P. K. (1998). Community violence and child development: A review of research. In P. K. Trickett & C. J. Schellenbach (Eds.), *Violence against children in the family and the community* (pp. 103-138). Washington, DC: American Psychological Association.

International Association of Chiefs of Police. (1999). *Guide for preventing and responding to school violence*. (Prepared by the Department of Defense Security Research Center). Available Online: www.theiacp.org/pubinfo/pubs/psllc/svres.htm

Johnson, K. (1998). *Trauma in the lives of children: Crisis and stress management techniques for teachers, counselors, and student service professionals* (2nd ed.). Alameda, CA: Hunter House.

778

Jones, R. T., Ollendick, T. H., McLaughlin, K. J., & Williams, C. E. (1989). Elaborative and behavioral rehearsal in the acquisition of fire emergency skills and the reduction of fear of fire. *Behavior Therapy, 20*, 93-101.

Juhnke, G. A. (1997). After school violence: An adapted critical incident stress debriefing model for student survivors and their parents. *Elementary School Guidance & Counseling, 31*, 163-170.

Keith, C. R., & Ellis, D. (1978). Reactions of pupils and teachers to death in the classroom. *The School Counselor, 25*, 228-234.

Klingman, A. (1985). Free writing: Evaluation of a preventive program with elementary school children. *Journal of School Psychology, 23*, 167-175.

Klingman, A. (1993). School-based intervention following a disaster. In C. F. Saylor (Ed), *Children and disasters* (pp. 187-210). New York: Plenum.

Klingman, A. (1996). School-based intervention in disaster and trauma. In M. C. Roberts (Ed.), *Model programs in child and family mental health* (pp. 149-171). Mahwah, NJ: Erlbaum.

Klingman, A., & Ben Eli, Z. (1981). A school community in disaster: Primary and secondary prevention in situational crisis. *Professional Psychology, 12*, 523-533.

Mazza, J. J., & Overstreet, S. (2000). Children and adolescents exposed to community violence: A mental health perspective for school psychologists. *School Psychology Review, 29*, 86-101.

McComb, B. (1978). Children require reality. *The School Counselor, 26*, 95.

Mihalik, S. (1978). Elementary counselors a must. *The School Counselor, 26*, 100-101.

Mitchell, J. T. (1983). When disaster strikes! The critical incident stress debriefing process. *Journal of Emergency Medical Services*, 8, 36-39.

Mitchell, J. T., & Everly, G. S., Jr. (1995). Critical incident stress debriefing (CISD) and the prevention of work-related traumatic stress among high risk occupational groups. In G. S. Everly, Jr. & J. T. Lating (Eds.), *Psychotraumatology: Key papers and core concepts in post traumatic stress* (pp. 267-280). New York: Plenum Press.

Mitchell, J. T., & Everly, G. S. (1998, Fall). Critical incident stress management: A new era in crisis intervention. *Traumatic StressPoints*, pp. 6-11.

Nader, K., & Pynoos, R. (1993). School disaster: Planning and initial interventions. Handbook of post-disaster interventions. [Special Issue]. *Journal of Social Behavior and Personality*, 8, 299-320.

Nelson, E. R., & Slaikeu, K. A. (1990). Crisis intervention in the schools. In K. A. Slaikeu (Ed.), *Crisis intervention: A handbook for practice and research* (2nd ed., pp. 329-347). Needham Heights, MA: Allyn & Bacon.

Newman, E., Kaloupek, D. G., Keane, T. M., & Folstein, S. F. (1997). Ethical issues in trauma research: The evolution of an empirical model for decision making. In G. Kaufman & J. L. Jasinski (Eds.), *Out of the darkness: Contemporary perspectives on family violence*. Thousand Oaks, CA: Sage.

Petersen, S., & Straub, R. L. (1992). *School crisis survival guide: Management techniques and materials for counselors and administrators*. West Nyack, NY: Center for Applied Research in Education.

Pitcher, G. D., & Poland, S. (1992). *Crisis intervention in the schools*. New York: Guilford Press.

Poland, S. (1997). School crisis teams. In A. P. Goldstein & J. C. Conoley (Eds.), *School violence prevention: A practical handbook* (pp. 127-159). New York: Guilford Press.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Poland, S., & Pitcher, G. (1990, Fall). Expect the unexpected. *School Safety*, pp. 14-17.

Putnam, F. W. (1996a). Posttraumatic stress disorder in children and adolescents. In L. Dickstein, M. B. Riba, & J. M. Oldham (Eds.), *Review of Psychiatry* (pp. 447-467). Washington, DC: American Psychiatric Press.

Putnam, F. W. (1996b). Special methods for trauma research with children. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 153-173). Lutherville, MD: Sidran.

Pynoos, R. S., Goenjian, A. K., & Steinberg, A. M. (1998). A public mental health approach to the postdisaster treatment of children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 7*, 195-210.

Pynoos, R. S., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*, 445-473.

Pynoos, R. S., Steinberg, A. M., & Goenjian, A. (1996). Traumatic stress in childhood and adolescence: Recent developments and current controversies. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 331-358). New York: Guilford Press.

Rappeport, J. R. (1978). Death education in the school. *The School Counselor, 26*, 93-94.

Roberts, M. C. (Ed.). (1996). *Model programs in child and family mental health*. Mahwah, NJ: Erlbaum.

Rose, S., & Bisson, J. (1998). Brief early psychological interventions following trauma: A systematic review of the literature. *Journal of Traumatic Stress, 11*, 697-710.

Rossi, P. H., Freeman, H. E., & Lipsey, M. W. (1999). *Evaluation: A systematic approach* (6th ed.). Thousand Oaks, CA: Sage.

Sandoval, J. (1987). Crisis intervention. In C. A. Maher & J. E. Zins (Eds.), *Psychoeducational interventions in the schools: Methods and procedures for enhancing student competence* (pp. 177-192). New York: Pergamon.

Schmuck, R. A. (1978). Feelings in the classroom. *The School Counselor, 26*, 98-100.

Schwartz, S. L. (1971). A review of crisis intervention programs. *Psychiatric Quarterly, 45*, 498-508.

Schwarz, J. H. (1982). Guiding children's creative expression in the stress of war. In C. D. Spielberger, I. G. Sarason, & N. A. Milgram (Eds.), *Stress and anxiety* (Vol. 7, pp. 351-354). Washington, DC: Hemisphere.

Scriven, M. (1967). The methodology of evaluation. AERA Monograph Series in *Curriculum Evaluation, No. 1*. Chicago: Rand McNally.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

780

Smith, E. M. (1996). Coping with the challenges of field research. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 126-152). Lutherville, MD: Sidran.

Stanford, G. (1978). An opportunity missed. *The School Counselor, 26*, 96-98.

State of Missouri. (1999). *School crisis response plan: A workbook and planning guide for school and community leaders*. Department of Elementary and Secondary Education and Department of Public Safety.

Taplin, J. R. (1971). Crisis theory: Critique and reformulation. *Community Mental Health Journal, 7*, 13-23.

Terr, L. C. (1989). Treating psychic trauma in children: A preliminary discussion. *Journal of Traumatic Stress, 2*, 3-20.

Tharp, R. B., & Gallimore, R. (1979). The ecology of program research and evaluation: A model of evaluation succession. In L. B. Sechrest (Ed.), *Evaluation studies review annual* (Vol. 4, pp. 39-60). Beverly Hills: Sage.

van der Kolk, B. A., McFarlane, A. C., & van der Hart, O. (1996). A general approach to treatment of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 417-440). New York: Guilford Press.

Vernberg, E. M. (1994). Evaluating the effectiveness of school-based interventions after large-scale disasters: An achievable goal? *Child, Youth, and Family Services Quarterly, 17*, 11-13.

Vernberg. E. M. (1999). Children's responses to disaster: Family and systems approaches. In R. Gist & B. Lubin (Eds.), *Response to disaster: Psychosocial, community, and ecological approaches* (pp. 193-209). Philadelphia: Brunner/Mazel.

Vernberg, E. M., & Vogel, J. M. (1993). Part 2: Interventions with children after disasters. Task Force Report. *Journal of Clinical Child Psychology, 22*, 485-498.

Wandersman, A., Imm, P., Chinman, M., & Kaftarian, S. (1999). *Getting to outcomes: Methods and tools for planning, self-evaluation and accountability*. Washington, DC: Center for Substance Abuse Prevention and National Center for the Advancement of Prevention. Available Online: www.stanford.edu/~davidf/empowermentevaluation.html

Wandersman, A., Imm, P., Chinman, M, & Kaftarian, S. (2000). Getting to outcomes: A results-based approach to accountability. *Evaluation and Program Planning, 23*, 389-395.

Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions following trauma at school. *Professional Psychology: Research and Practice, 21*, 271-278.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). Thousand Oaks, CA: Sage.

Young, B. H., Ford, J. D., Ruzek, J. I., Friedman, M. J., & Gusman, F. D. (1999). *Disaster mental health services: A guidebook for clinicians and administrators*. Available Online: www.dartmouth.edu/dms/ptsd/DMHS

Yule, W., Bolton, D., Orlee, U., Boyle, S., O'Ryan, D., & Nurrish, J. (2000). The long-term psychological effects of a disaster experienced in adolescence: I: The incidence and course of PTSD. *Journal of Child Psychology and Psychiatry, 41*, 503-511.

Endnote

[1] Established in 1992 by The Section on Clinical Child Psychology and the Division of Child, Youth, and Family Services of the American Psychological Association.

Opportunity Blowing Upon an Ill Wind

危機

Philip J. Lazarus, Ph.D.
Florida International University

Shane R. Jimerson, Ph.D.
University of California, Santa Barbara

During the past decade, school communities across the United States have been impacted by crisis events. Through these tragedies, we have learned that no one is immune to disaster—it can occur at any place, at any time. Many children, families, communities, and educational professionals have been affected by the tragic bombing in Oklahoma City and by the senseless school shootings that have occurred in cities all the way from Bethel, Alaska, to Lake Worth, Florida. Over the past decade, an average of about 10 young people have been killed every day in America (Thornton, Craft, Dahlberg, Lynch, & Baer, 2000). Homicide is currently the second leading cause of death among our nation's youth aged 15 to 19 (Thornton et al., 2000). Moreover, according to the Children's Defense Fund (1999), in America a young person commits suicide every four hours. The three most common causes of death among our youth—accidents, homicides, and suicides—are all preventable.

Each of us associated with this book is committed to prevention. We find these statistics disconcerting and are determined to find solutions. For the sake of our nation's youth and for the future of our country, we will not give in to despair, cynicism, and self-doubt. Instead, we will move forward with diligence and hope. Hope is the essence of this book. Supporting this sense of hope is the observation that schools have been and continue to be relatively safe places. Although one school shooting is one too many, recent data suggest that only about 1 out of every 100 violent deaths (i.e., suicide and homicide) are associated with schools (Kaufman et al., 2000). In other words, schools are arguably one of the safest places for our young people. Given this observation, it is important to acknowledge and to document that our schools already have in place a variety of effective prevention programs.

We hope this book provides fresh ideas and valuable insights regarding how to further the development of safe, responsive, and effective schools; confront the problems of youth violence; and heal children who have been affected by tragic events. We hope this book inspires the creation of new programs and models that will assist troubled young people to cope with the anxiety, anger, and turmoil that are often part of their daily lives.

As Albert Einstein once observed, "the significant problems we face cannot be solved at the same level of thinking we were at when we created them." This book is about the hope of creating solutions. As children develop within the ecological contexts of families, schools, and communities, we must each embrace the responsibility of facilitating the healthy development of youth by addressing problems, providing appropriate support and assistance, and enhancing their social, emotional, and cognitive competence.

Years ago, it was not uncommon that, when a crisis occurred in schools, the typical reaction was to look the other way. When the first author was in junior high school, a young boy who sat next to him in class died in a horrible car accident. It seemed that the school ignored his death. Rumors circulated that drinking may have been involved. There were important lessons to be learned, but these lessons were never taught.

Following natural disasters, such as the hurricanes that struck South Carolina and south Florida, and after the bombing in Oklahoma City, many schools did not have crisis plans in place to guide response efforts. As crisis intervenors, we responded but did so using more of a "seat of the pants" approach than one that was well-designed, planned, and informed by research. Again, there were many lessons to be learned, but we were never taught.

As the Assistant Surgeon General Brian Flynn noted in this book's foreword, the fundamental message of this book is one of both help and hope. Now there are many lessons to be learned because we have new models (Dwyer & Osher, 2000) and information to guide us. Books on the topic of preparing for crises in schools (Brock, Sandoval, & Lewis, 2001) and coping with crisis (Poland & McCormick, 1999) are also available to help school personnel. The U.S. Department of Education has published two major works—*Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer, Osher, & Warger, 1998) and *Safeguarding our Children: An Action Guide* (Dwyer & Osher, 2000), which have been distributed to school systems all across the country and are also available on the Internet. These documents provide guidance on making schools safer. The National Association of School Psychologists has published *Crisis Prevention & Response: A Collection of NASP Resources* (Canter & Carroll, 1999) and the National Education Association (NEA) has produced a *Crisis Communication Guide and Toolkit* (NEA, 2000). The Surgeon General's office has supported three major publications aimed at national problems that impact our youth. These publications are *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999), *Youth Violence: A Report of the Surgeon General* (U. S. Department of Health and Human Services, 2001), and a *National Strategy for Suicide Prevention* (U. S. Department of Health and Human Services, 2001). These documents were designed to be catalysts for social change with the power to transform policies, attitudes, and services. All three documents provide the latest scientific evidence and a vision for

784

future action. The Centers for Disease Control and Prevention has published *Best Practices of Youth Violence Prevention: A Sourcebook for Community Action* (Thornton et al., 2000). In addition, authors of the chapters in this book have been engaged in disseminating information about crisis prevention and response and in training school personnel all over the world on effective practices. As new knowledge emerges, it has become unequivocal that a variety of professions, associations, and concerned citizens must come together to prevent and respond to school crises.

The Chinese symbol for crisis has been represented as "opportunity blowing upon an ill wind." There is much wisdom in this description. The school crises that we have confronted have brought forth a great deal of energy from different professions. As a result of the Oklahoma City bombing, the National Association of School Psychologists established the National Emergency Assistance Team whose mission was to respond to crisis events that impacted schools and children. From this Team's activities, school psychologists began to be included in public policy decisions. In this way, educators were given the opportunity to discuss the mental health needs of students and describe the supports needed to enhance healthy development.

We are aware of many strategies that promote prosocial behaviors, support students in need, and reduce the prevalence of violent behavior. These include:

- Teaching skills to resolve problems nonviolently.
- Promoting nonviolent norms.
- Minimizing both the availability and acceptance of weapons.
- Using practices that promote connections of youth to prosocial institutions.
- Using effective instructional practices that promote academic success.
- Connecting schools to positive social institutions that support nonviolent solutions to problems.
- Initiating specific programs in the area of peer mediation, conflict resolution, anger management, bully proofing, social skills training, and problem solving that have been found empirically to reduce violent solutions to problems.
- Emphasizing not only the development of academic competence, but also social and emotional competence.
- Ensuring that students are the central element in a safe school plan.
- Creating a climate of caring, which demonstrates that every student is important.

- Including parent programs, which support academic and extracurricular activities that foster interaction among parents, teachers, school staff, and students.

- Supporting multidisciplinary mental health teams (composed of school psychologists, counselors, and social workers) that conduct assessments, provide counseling to troubled students, and offer consultation to school staff regarding academic, emotional, and behavioral problems of students (Lazarus, 2001).

If schools adopt these strategies they have an opportunity to reduce the likelihood of crises.

Editing this book has also provided us a great opportunity. It was an incredible privilege and responsibility to work with authors with world-class expertise who feel passionately about making lives of young people safer. As stated by Rear Admiral Flynn in this volume's Forward, "there seems to be a growing intolerance for accepting the gap between our national identity as strong and compassionate problem solvers and the pain and danger in which so many of our young people find themselves (p. xii)." We hope that this book spurs new models, programs, and research that will make the lives of children safer. Through this book we have provided best practices on how to prevent school crises from occurring, how to intervene effectively when they do, and how to ameliorate the emotional pain and suffering of young people.

As Joseph Campbell once said, "follow your passion." Our passion was to make a difference by providing information that may make it less likely for crises to occur in the first place and that will facilitate the response to those tragedies that do occur. For that privilege we are grateful to all the professionals who contributed to this volume. Indeed, there is "opportunity blowing upon an ill wind."

786

References

Brock, S. E., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York: Wiley.

Canter, A., & Carroll, S. (1999). *Crisis prevention & response: A collection of NASP resources*. Bethesda, MD: National Association of School Psychologists.

Children's Defense Fund. (1999, February). Moments in America for children. *NASP Communiqué, 27*(5), 6.

Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide*. Washington, DC: U.S. Departments of Education and Justice, American Institutes for Research. Available Online: www.ed.gov/offices/OSERS/OSEP/ActionGuide

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools*. Washington, DC: U. S. Department of Education. Available Online: www.ed.gov/offices/OSERS/OSEP/earlywrn.html

Kaufman, P., Chen, X., Choy, S. P., Ruddy, S. A., Miller, A. K., Fleury, J. K., Chandler, K. A., Rand, M. R., Klaus, P., & Planty, M. G. (2000, October). *Indicators of school crime and safety, 2000*. Washington, DC: U.S. Departments of Education and Justice. Available Online: www.ojp.usdoj.gov/bjs or http://nces.ed.gov

Lazarus, P. J. (2001). *Guidelines for establishing violence prevention programs in Catholic schools*. Lisle, IL: National Catholic Risk Retention Group, Inc.

National Education Association. (2000). *NEA crisis communication guide and toolkit*. Washington, DC: Author.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Thornton, T. N., Craft, C.A., Dahlberg, L. L., Lynch, B. S., & Baer, K. (2000). *Best practices of youth violence prevention: A sourcebook for community action*. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Available Online: www.surgeongeneral.gov/library/mentalhealth/home.html

U. S. Department of Health and Human Services. (2001). *National strategy for suicide prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, National Institutes of Health, Health Resources and Services Administration. Available Online: www.mentalhealth.org/publications/allpubs/SMA01-3517

U. S. Department of Health and Human Services. (2001). *Youth violence: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health. Available Online: www.surgeongeneral.gov/library/youthviolence/report.html

Editor Biographies

危機

Stephen E. Brock, Ph.D., NCSP

Dr. Brock is an Assistant Professor at California State University, Sacramento (CSUS), where he trains school psychologists. A member of the California Association of School Psychologists (CASP) Board of Directors, Dr. Brock is co-chairperson of the Crisis Intervention steering committee and is on the editorial board of *The California School Psychologist*. He was recently elected Coordinator of the National Association of School Psychologist's (NASP) Crisis Management Interest Group. He is married to Christine Brock (a sixth-grade teacher) and has two children, Dyana (age 13) and David (age 11).

As a Licensed Educational Psychologist and Nationally Certified School Psychologist, Dr. Brock had more than 15 years of practical school psychology experience before joining the CSUS faculty in the fall of 2001. Among his school psychology career highlights was recognition as an "Outstanding School Psychologist" by CASP.

Dr. Brock's areas of research interest include attention-deficit/hyperactivity disorder (ADHD), school-based crisis response, and suicide prevention. His dissertation research documented that children with ADHD have significant reading comprehension difficulties. Other contributions to the study of ADHD include numerous publications and state and national conference presentations. His contributions to the study of school crisis response and suicide prevention also include numerous state and national conference presentations. His most prominent publication in this area is the book he wrote with Jonathan Sandoval and Sharon Lewis, *Preparing for Crises in the Schools: A Manual for Building School Crisis Response Teams* (published by John Wiley & Sons). His other publications include over three dozen articles and book chapters on developing crisis response teams, suicide prevention and postvention, crisis counseling, and youth violence.

Philip J. Lazarus, Ph.D., NCSP

Dr. Lazarus is an Associate Professor and Director of the School Psychology Training Program at Florida International University. He is a founding member and chairperson of the National Emergency Assistance Team of the National Association of School Psychologists and co-chair of the Florida Emergency Assistance Team of the Florida Association of School Psychologists (FASP). These teams have provided direct crisis assistance in the aftermath of tragic school shootings as well as natural disasters.

During his career, Dr. Lazarus has served as president of the FASP; founding member and chairperson of the Board of Examiners in School Psychology for the Florida Department of Professional Regulation; chairperson of the Council of Trainers and Supervisors of Florida School Psychologists; founding director of Camp Giborim (a camp for mentally and physically challenged youths); and founding director and vice-president of the FASP Children Services Fund, Inc.

Dr. Lazarus is the co-editor of the text, *Psychoeducational Evaluation of Children and Adolescents with Low-Incidence Handicaps* (originally published by Grune & Stratton). He has written 10 book chapters and more than three dozen scholarly articles, and has given numerous national and international presentations. His current research interests include crisis prevention and response, suicide prevention, and emotional intelligence.

Dr. Lazarus has also maintained a private practice for 20 years. He specializes in working with troubled children, adolescents, and families, and also consults with schools, law firms, and businesses. He consulted with the Federal Bureau of Investigation in its landmark study on profiling school shooters and is now working as lead expert on school violence prevention for VIRTUS of the National Catholic Risk Retention Group, Inc. He is married to Jane Lazarus (who is also a school psychologist) and they have a teenage son, Adam.

Shane Jimerson, Ph.D., NCSP

Dr. Jimerson is a faculty member in the Gevirtz Graduate School of Education at the University of California, Santa Barbara, with both the Counseling, Clinical, and School Psychology program and the Child and Adolescent Development program. Dr. Jimerson's research areas and interests include developmental psychopathology, early reading assessment, achievement trajectories, outcomes associated with early grade retention, the development of high school dropouts, the efficacy of early intervention programs, children's grief and adaptation in response to a loss, and school crisis prevention and intervention. Much of his research has emphasized the importance of the interplay between socioemotional and cognitive development impacting academic achievement and educational success and has also highlighted the influence of early experiences on subsequent development.

A few of his most cherished professional experiences include work during the past decade with bereaved children and families; work with students, families, administrators, communities, and schools providing support and assistance in both crisis prevention and intervention activities; and receiving the "Best Research Article" of the year award from the Society for the Study of School Psychology in both 1998 and 2000. He is married to Dr. Kathryn O'Brien.

Dr. Jimerson serves on multiple state, national, and international committees and boards, including the California Association of School Psychologists, the National Association of School Psychologists, and the International School Psychology Association, to provide leadership aimed at promoting the social and cognitive competence of youth. Dr. Jimerson is the co-author of a five-book series for professionals working with bereaved youth, entitled *The Mourning Child Grief Support Group Curriculum* (published by Brunner & Routledge). In addition, Dr. Jimerson serves as the editor of *The California School Psychologist* journal and is on the editorial boards of the *Journal of School Psychology* and the *Journal of Early Childhood Research and Practice*.

Contributors 危機

Bonnie Aberson
School Psychologist; Miami-Dade County Public Schools
National Trainer; I Can Problem Solve

Michael Bates
Assistant Researcher, Gevirtz Graduate School of Education;
University of California, Santa Barbara

Stephen E. Brock
Assistant Professor, Department of Special Education, Rehabilitation, and School Psychology; California State University, Sacramento

Robert B. Brooks
Clinical Psychologist; Harvard Medical School and McLean Hospital

Michael B. Brown
Associate Professor and Director of Graduate Studies, Department of Psychology; East Carolina University

Jody Browning
Doctoral Student, Benerd School of Education; University of the Pacific

John Davis
Assistant Professor; California State University, Hayward
Raskob Learning Institute, Holy Names College

Patricia Del Valle
Assistant Professor, School Psychology; Florida International University

James C. DiPerna
Assistant Professor of Education and Human Services; Lehigh University

Kevin P. Dwyer
Senior Advisor, Prevention and Children's Mental Health;
National Mental Health Association

Stephen Elliott
Senior Research Associate; Wisconsin Center for Education Research
Professor, Department of Educational Psychology; University of Wisconsin-Madison

Ted Feinberg
Assistant Executive Director; National Association of School Psychologists

Brian Flynn
Assistant Surgeon General, Director of Program Development, Special Populations, and Projects; Center for Mental Health Services

Michael J. Furlong
Professor, Counseling, Clinical, and School Psychology;
University of California, Santa Barbara

Carla Garrity
Child Psychologist; Neuro Developmental Center (Denver, CO)

Barry Glick
Chief Operations Officer and National Consultant;
G & G Consultants, LLC (Scotia, NY)

Arnold P. Goldstein
Professor Emeritus, Psychology and Education; Syracuse University

Susan Gorin
Executive Director; National Association of School Psychologists

Leland C. Huff
School Psychologist;
Huntington Beach Union High School District (Huntington Beach, CA)

Susan Jacob
Professor of Psychology; Central Michigan University

Kathryn Jens
School Psychologist; Cherry Creek School District (Englewood, CO)

Shane R. Jimerson
Assistant Professor, Counseling, Clinical, and School Psychology;
University of California, Santa Barbara
Assistant Professor, Child and Adolescent Development;
University of California, Santa Barbara

John Kalafat
President-Elect; American Association of Suicidology
Professor, Graduate School of Applied and Professional Psychology; Rutgers University

Avigdor Klingman
Professor, Counseling and Therapy Program, Faculty of Education;
University of Haifa, Israel
Head for Crisis Intervention; Ministry of Education, Israel

Libby Kuffner Nealis
Director of Public Policy; National Association of School Psychologists

Philip J. Lazarus
Associate Professor, School Psychology; Florida International University
Chairperson, NASP National Emergency Assistance Team

Sharon Lewis
Lead School Psychologist; Lodi Unified School District (Lodi, CA)

Richard Lieberman
School Psychologist, Suicide Prevention Unit; Los Angeles Unified School District

Brian McKevitt
Department of Educational Psychology;
University of Wisconsin-Madison
Currently with Heartland Area Education Agency 11, Johnston, Iowa

Paulette Muni
Private Practice; Goshen, New York

Robert D. Myrick
Professor, Counselor Education Department, College of Education;
University of Florida

Kathleen Nader
Psychotherapist, Consultant, and Director; Two Suns (Cedar Park, TX)

Amanda Nickerson
Graduate Student, Department of Psychology; University of South Carolina

Pauline Pagliocca
Assistant Professor, Department of Psychology; University of South Carolina
(Currently with Victims of Violence Program, Department of Psychiatry; Harvard Medical School and the Cambridge Hospital)

Renee Pavelski
Doctoral Candidate, Counseling, Clinical, and School Psychology;
University of California, Santa Barbara

William Pfohl
Professor of Psychology; Western Kentucky University

Scott Poland
Past-President; National Association of School Psychologists
Director of Psychological Services;
Cypress-Fairbanks Independent School District (Houston, Texas)

William Porter
Assistant Director, Student Achievement Services;
Cherry Creek School District (Englewood, CO)

Philip A. Saigh
Professor, Doctoral Program in Educational Psychology, Graduate School and University Center; City University of New York

Jonathan Sandoval
Professor, Division of Education; University of California, Davis

Jill Saxton
Doctoral Student, Special Education and Risk Studies;
University of California, Santa Barbara

Myrna B. Shure
Professor, Department of Clinical and Health Psychology;
MCP Hahnemann University

Ronald Stephens
Executive Director; National School Safety Center

Sally Stoker
Social Worker, Steering Committee; Bully-Proofing Your School (Denver, CO)

Linda Webster
Associate Professor, Benerd School of Education; University of the Pacific

Stephanie Williams
Graduate Student, Department of Psychology; University of South Carolina

Alan D. Wolfelt
Founder and Director; Center for Loss and Life Transition (Fort Collins, CO)

Anastasia E. Yasik
Assistant Professor, Psychology Department; Pace University

Marlene A. Young
Executive Director; National Organization for Victim Assistance

Index

危機

abused children, group play therapy: 682-683
academic enablers, social skills as: 153-154
accidents: xv, 333, 792
acculturative stress, refugees: 605-606
acute distress: 10-13, 370
adaptation: 775
administrative considerations: 95-108
  individual intervention: 405, 407
  refugees: 606-607
  treatment: 421-422
adult supervision: 50-51, 57
advocacy, for crisis prevention and intervention: 733-754
  how to advocate: 744-750, 753
  refugees: 607
age
  grief and: 319-320
  trauma and: 312-314
aggression: 156-160
aggression replacement training (ART): 225-248
  application innovations: 229-231
  curriculum: 244-248
  evaluation: 231-235
alcohol abuse: 52-53
Anger Control Training: 228
Anger Coping Program: 158
Annsville Youth Center: 231-233
arousal symptoms, treatment: 691-692
art, expressive, refugees: 608-609
assessment: 345
assumptions, intervention practice: 774-777
attachment: 507-510
  theory: 311-312
attribution theory: 73-74
automobile and parking policies: 55
autonomy: 75
barriers to learning: 741-744
behavioral mediation hypothesis: 112
behaviors, measurement: 759-760
belief system: 378
bibliotherapy, refugees: 609
blame: 68-69
bullies: 172, 181
  thinking errors: 175
Bully Busters: 185-186
bullying: 51-52, 61, 171-189
  prevention programs: 173-186
  protective skills: 179-181
Bullyproof: 185
Bully-Proofing Your School: 174-183
bus plan, bully prevention: 182-183
bystanders: 172

causality, death: 319
changes, and symbolic behavior: 416-417
child maltreatment, psychological and behavioral effects: 503-530
  culture: 510
  developmental issues: 507-510
  intervention: 512-516
  prevention: 511-512
  resources: 522-530
choice making: 83
classroom
  behaviors: 765
  environment: 67-93
  -focused interventions, war: 588-592
  indicators of stress: 416-417
  intervention: 385-390
  sudden death
    announcement: 470
    discussion: 472-476
clinical interviews: 417-418
  caregiver: 620-621
  child-adolescent: 621-628
  comorbid psychiatric conditions: 629-630
  parents: 628-629
  PTSD diagnosis: 619-620, 620-630
  structured: 622-630
  unstructured: 620-622
closing: 396
cognitive behavioral therapy: 684-687
  EMDR: 685-686
  individual trauma-focused: 684-685
  PTSD: 639-652
  trauma-focused coping: 686-687
cognitive development, grief and: 320-322
collaboration, refugees: 607
Columbine High School: xiii, 47
communication: 33-34, 56, 342, 349
  language and: 298-301
  nonverbal: 301-302
community
  -based evaluation: 234-235
  child maltreatment: 512
  -focused interventions, war: 583-584
  response: 333-354
  sudden death: 461-462, 465
competence: 75, 76-78
confidentiality: 720-721
conflict: 191-194
  victims: 192-194
conflict resolution: 191-209
connectedness: 75
Constitution: 710-711
  4th Amendment: 713
  14th Amendment: 710
  torts: 99-102
consultants and consultation
  refugees: 607
  war: 587-588
contagion, suicide: 554-555, 556
contextual considerations: 419-424
  sudden death: 450
coordinator: 348
coping
  child maltreatment: 511
  strategies: 375
  style: 437-438
Coping with Crisis: 278-280
corrective dénouement play therapy: 680
counseling, culture and: 305
counselor, culture and: 294-296
courts: 710-711
crisis
  event classifications: 7-8, 9
  nature of: 336
  type: 357-359
CRISIS (Confidential Reporting of Individuals suspected of Imminent School Violence): 739
crisis intervention: 104, 338-339, 347-349, 494-498
  child maltreatment: 512-516
  culture and: 305-306
  direct: 513-515, 777-778
  during: 411-415
  follow-up: 389-390
  group: 385-403
  ICPS research: 116-123

  immediate: 411-415, 492-496
  indirect: 515-516
  individual: 405-428
  initial: 411-412
  long-term: 496-498
  multiple-level involving significant adults: 778-780
  preparation: 405-411
  procedures: 567-570
  refugees: 608-610
  research and evaluation: 771-790
  sudden death: 456-465
  suicide: 540, 543, 546-547, 557-558, 567-570
  team: 423
  treatment: 419-424
  triage and debriefing: 415-418
  venue: 387-388
  war: 582-593

Crisis Intervention in the Schools: 275-276

crisis response: 60, 105, 337-338
  district-level: 363
  estimating the appropriate response: 355-365
  facilities: 341
  gender: 439
  guidelines: 285-286, 360-363, 560
  identification: 342
  key lessons: 334-336
  legal and ethical issues: 726-727
  mutual-aid-level: 362-363
  natural disaster: 438-444
  NOVA model plan: 339-350
  options: 356
  plan: 284-285, 345, 458-462
  school-level: 361-362
  sudden death: 462-465
  suicide: 558-559, 560
  team: 283-284, 340-341, 349, 558-559
  validity: 761

crisis state
  characteristics: 10, 12
  defined: 8-9
  development: 14
  response: 13-16
  response options: 14
  symptoms: 11, 13

culture and ethnicity
  child maltreatment: 510
  grief: 321-322
  intervention and: 293-308
  intervention protocol: 305-306
  perception: 296-298
  refugees: 605-606
  response: 298-305, 439-440
  school violence: 489-491
  sudden death: 453-456
  suicide: 537-538, 557
  trauma and: 316
  variation: 294-296
  war: 581

danger doctrine: 100-102

data guidance: 784

dating violence: 764

death: xv, 342-343
  context: 450
  culture and ethnicity: 453-456
  developmental considerations: 317-319, 452-453
  grief: 451
  intervention: 456-465
  intrapersonal adjustments: 451
  memorials: 343
  notification: 343
  preparation: 465-466
  special needs youths: 450-451
  sudden: 449-485, 653-655

debriefing: 415-418, 460, 775
  suicide: 572

Deci's approach: 74-76

decision making: 83

decompensation stage: 603

delinquency, prevention: 738

depersonalizing: 7

depression: 160-162

developmental issues: 452-453
  child maltreatment: 507-510
  grief: 316-322
  level: 376
  normal: 310-312

  play therapy: 682
  refugees: 604
  suicide: 536-537, 556
  trauma and: 312-316
  war: 581
Diagnostic and Statistical Manual of Mental Disorders: 7-8
directive play therapy: 679-680
  group: 683-684
discipline: 716-719
  problems: 51-52
disfigurement, war and: 579
disruptive behavior: 156-160
dissociative disorders, treatment: 690-691
doctrine of nonliability: 96-97
documentation: 105-106
dress: 304
  regulation: 54, 718-719
drop-outs: 49-50
drug abuse: 52-53
duration: 359, 369
dynamic play therapy: 681-682
early intervention: 34-35, 41, 263, 264, 265, 266
early warning signs: 36-37
Early Warning, Timely Response: A Guide to Safe Schools: 734
earthquakes: 435
Educational Excellence for All Children Act: 737-738
effective schools, checklist: 32
Elementary and Secondary Education Act (ESEA): 737, 738, 740
emotional development, sudden death: 452-453
emotional distance: 409
emotional problems, refugees: 608
emotional reactions, suicide: 555
emotional reactivity: 437
empathy: 69-70
empowerment: 395-396
environment, school: 53, 103
ethics: 720-728
  evaluation: 781-782
  PTSD treatment: 647-648
  violence prevention: 267-268
ethnicity. *See* culture and ethnicity
ethnic-racial violence: 764
evaluation
  future: 780-784
  guiding questions: 782-783
  individual: 415
  intervention: 771-790
  prevention programs: 40
  response: 60
  ways of knowing: 783-784
expectations: 79-81
experimental design, PTSD treatment: 646-647
experimentation: 783
exposure: 314, 368-369
expulsion: 716-717
eye contact: 301
eye movement desensitization and reprocessing (EMDR): 643-645, 685-686
facilitators, GCI: 388-389
fact sheets: 776
faculty. *See* school, personnel; teachers
failure, dealing with: 86-87
faith: 378
family: 304-305
  abuse: 687-688
  natural disasters: 436-437
  resources: 373-374
  suicide: 561-562
  violence: 495-496, 497
Family Educational Rights and Privacy Act (FERPA): 715-716
FBI model: 260
financial resources: 374
first aid: 412-413, 414, 493-494
flooding: 640, 642
floods: 436
follow up: 498
  suicide intervention: 547
food: 303
free and appropriate public education (FAPE): 741
funding: 341

future
  evaluation: 780-784
  innovative treatment methods: 692-694
  PTSD diagnosis: 631-632
  PTSD treatment: 648
gang intervention project: 236-237
gay/lesbian/bisexual violence: 764-765
gender: 315-316, 321, 439, 655, 763
gestures: 301-302
gifts: 304
grief: 653-674
  developmental issues: 316-322
  -focused therapy: 679-680
  myths: 666-670
  reconciliation: 657-665, 670
  sudden death: 451, 477-485
  suicide: 556
grieving child's bill of rights: 674
Group Crisis Intervention (GCI): 386-390
  advantages: 397-398
  contraindications: 390
  model: 390-399
  post-GCI activities: 396-397
  research suggestions: 399
group intervention: 385-403, 494-495, 497
  culture and: 305
  size: 386-387
group play therapy: 682-684
  abused children: 682-683
  directive: 683-684
guiding questions, evaluation: 782-783
harassment: 52
hate-based violence: 764-765
hazing: 52
high-risk populations: 341
holidays: 302
homicide, xv: 334, 351, 385
  grief and: 654
hope: 78-79
  fostering: 79-88
human motivation theory: 310-311
Hurricane Andrew: 433
hurricanes: 434
ICPS. *See* problem-solving
imminent warning signs: 37
impact potential: 7
implementation, ICPS, classroom: 123-124
Improving America's Schools Act (IASA): 712
in-crisis protocol: 345-350
individual trauma-focused cognitive behavioral therapy: 684-685
individual-focused interventions, war: 592-593
individuals at risk: 367-383
Individuals with Disabilities Education Act (IDEA): 715, 734-735
information dissemination: 342
information sharing: 58, 714-716
  suicide: 562-563
informed consent: 721
infrastructure, damaged or destroyed: 580
injury, war and: 579
inner city children and adolescents, treatment: 688-689
intellectual functioning: 376
intensity: 359-360
interagency cooperation: 59
intermediate grades, ICPS training: 115, 117-118
Internet: 745-748
interpreters: 299-301
  refugees: 607
intervenors, refugees: 607-608
interviews. *See* clinical interviews
intrapersonal adjustments, sudden death: 451
irreversibility, death: 318
Japanese students, sudden death: 455
Juvenile Justice and Delinquency Prevention Act: 738-739
juvenile justice system: 714-715
kindergarten, ICPS training: 113-115, 116-117, 119-120

language
  refugees: 605-606
  traumatic events and: 298-301
laws: 54
lawsuits: 96-98, 102-103
leadership: 27-28, 346
learning problems, refugees: 608
legal issues: 96-103, 709-728
  constitutional torts: 99-102
  danger doctrine: 100-102
  doctrine of nonliability: 96-97
  lawsuits: 96-98, 102-103
  liability: 96
  special relationship doctrine: 99-100
  suicide intervention: 535
legislation: 711-712, 737-740
  antidiscrimination legislation: 102-103
  dangers: 739-740
  opportunities: 739
lessons learned, Santee, CA: xvi-xvii
liability, civil: 96
life threat, degree: 314
listservs: 749
literature review: 336-339
lockers: 54
locus of control: 378
loss: 315
maladaptive coping, psychological problems associated with: 12
management: 346, 759-762
mediators, child maltreatment: 506-507
medical care: 344-345
memorials: 343, 347, 570-571, 776
mental health: 375-376
  war and: 579
mental health professional, ICPS and: 124-125
migration stage: 601-602
migration. *See* refugees
mission statement: 53
mistakes, dealing with: 86-87
monitoring, violence prevention: 238-239
Moral Reasoning Training: 228-229
mothers, training provided by: 119-120
motivation: 79-88, 239-240
mourning
  grief and: 666
  reconciliation needs: 657-665
multidisciplinary teams: 335-336
multimodal treatment methods: 687-689
  family treatment for abuse: 687-688
  inner city children and adolescents: 688-689
multiple loss, grief and: 655
music: 304
National Emergency Assistance Team (NEAT): xvii
National Organization for Victim Assistance (NOVA): 333, 351
  model for school crisis response: 339-350
  training curriculum: 339
natural disasters: 333, 433-447, 792
needs assessment: 29-30
  refugees: 608
news media: 346, 349-350, 360, 460-461
  suicide: 559, 564
  war: 584
No-Bullying: 185
nonfunctionality, death: 318-319
nonverbal communication: 301-302
NOVA, sudden death: 456-457, 461
number of people involved: 360
Oklahoma City: xi, 334
outcomes, measuring: 693-694
parents
  bully prevention: 182
  ICPS: 115-116, 125
  management training: 159-160
  natural disasters: 436-437
  school violence: 494
  sudden death: 460, 472
  suicide intervention: 543, 546-547
  trauma and: 315
peace officer: 58
peer mediation
  change and: 195-205
  models: 198-201, 202
  value of: 205-206

801

peers, sudden death: 453
perception, culture and: 296-298
personal knowing: 783-784
physical contact: 301-302
physical health, grief and: 656-657
plane crash: 350
planning
  administrative support: 25
  barriers: 25-26
  long-range: 350
  process: 28-29
  safety ad security: 53-54
  team: 24-30
  violence prevention: 237-238
play therapy: 678-684
  corrective dénouement: 680
  developmental: 682
  directive: 679-680
  dynamic: 681-682
  group: 682-684
  refugees: 610
  relationship-focused: 681-682
police, on campus: 714
policies: 28, 35
  development: 54-55
Positive Alternative Learning (PAL) Program: 229-230
positive relationships: 31, 33
post office massacre: 333
posttraumatic stress disorder (PTSD): 7-8, 14, 15, 337, 356-360, 489, 490, 492
  child maltreatment: 504
  clinical interviews: 620-630
  diagnosing: 619-637
  ethics: 647-648
  experimental design: 646-647
  future: 631-632, 648, 692
  inventory: 625-626
  quasi-experimental designs: 645-646
  self-report inventories and rating scales: 631
  single-case research designs: 641-645
  treatment: 639-652
predictive validity: 761-762
preimmigration stage: 601
preparedness: 13, 103-106, 273-288, 776-777
  defined: 273-274
  recommendations: 283-286
  research needs: 281-282
  strategies: 275-282
  sudden death: 465-466
Preparing for Crises in the Schools: 280-281
preschool, ICPS training: 113-115, 116-117
prevention: 37-40, 55-56, 57, 58, 131-149, 791
  child maltreatment: 511-512
  current status: 756-758
  domains: 136-138
  ethical and research considerations: 267-268
  guidelines: 734-737
  legislation: 737-740
  model programs: 266--267
  neglected issues: 763-765
  planning: 23-46
  primary: 13-15, 21-288, 252-254
  program design: 762-763
  program evaluation: 40
  programs: 142-149
  refugees: 606-608
  research barriers: 758-763
  research needs: 755-770
  resources: 133-136
  secondary: 14, 15, 254-264, 265, 266, 291-614
  targets: 134-137
  team: 26-27
  tertiary: 14, 15-16, 264-266, 617-704
  war: 582-583
primary grades, ICPS training: 113-115, 119-120
Primary Intervention Project (PIP): 503
probation: 715
probation officer: 59
problem behaviors: 411
problem solving: 83-84, 159
  dialogue: 122

802

  implementation: 123-125
  interpersonal cognitive: 109-130
  parents and: 125
  replication: 120-121
  research: 111-113, 116-123
  school mental health professional and: 124-125
procedures, establishment: 55-57
programs
  design: 37-40, 76, 762-763
  management: 237-241
prosocial behaviors: 793-794
proximity: 301
psychological adjustment, refugees: 604
psychological trauma: 309-331
  contextual variables: 314-316
pyramid procedure: 585-586
qualitative methods: 783-784
quasi-experimental designs, PTSD treatment: 645-646
reconciliation
  child's grief: 670
  needs of mourning: 657-665
reentry, school violence: 496-497
referrals: 418
  suicide intervention: 547, 564-565
refugees: 599-614
  acculturative stress: 605-606
  cultural issues: 605-606
  intervention: 608-610
  prevention: 606-608
  psychological adjustment: 604
  resettlement stages: 600-604
regression: 417
relationship-focused play therapy: 681-682
religion: 302-303
relocation: 436
reporting death, suicide: 563-564
research
  barriers: 758-763
  current status: 756-758
  intervention: 771-790
  neglected issues: 763-765
  prevention, needs: 755-770
resettlement stages: 600-604
resilience: 78-79
  fostering: 79-88
  personal: 371-378
resources
  directory: 341
  personal: 373-374
responsibility: 81-83
responsive classroom: 162-164
  effectiveness research: 164-165
responsive school: 31, 33
reuniting procedures: 411
risk assessment: 254-255, 258-259, 260, 261-263
  suicide, referral data: 541-542
  student interview: 544-545
risk factors
  awareness: 407-408, 410
  management: 103-106
  measurement: 759-760
  suicide: 533-535, 566
risk-taking behaviors, treatment: 689-690
rule making, shared: 85-86
rumor control: 349, 392-393
safe schools
  core elements: 30-37
  duty to ensure: 711
Safeguarding Our Children, An Action Guide: 734
safety committees: xviii
Santee, California: xvi
school
  -based team approach: 24
  closure, war and: 579
  -community collaboration: 35
  damaged or destroyed: 580
  -focused interventions, war: 584-587
  personnel: 31, 33, 104-105, 606-608
  reorganization, war: 587-588
  rules: 55
  safe: 35, 47-65
School Crisis Management: 277-278
School Crisis Survival Guide: 276-277
school district, Erie, PA: 230-231

803

School Emergency Response to Violence (SERV): 736-737
School Psychology Action Network (SPAN): 745
screening programs: 62
search and seizure: 713-714
security, increased on campus: 713-714
self-confidence: 378
self-determination: 75
self-discipline: 84-86
self-esteem: 70-76, 378
  definition: 72
  fostering: 79-88
self-identity, mourning and: 661-663
self-regulation of emotion: 376
self-report inventories and rating scales, nondiagnosis: 631
severity: 359-360
sexual orientation
  suicide: 537-538
  violence: 764-765
shamans: 303
sharing
  information: 58, 714-716
  reactions: 394-385
  stories: 393
shelters: 341-342
skillstreaming: 225-227
social learning theory: 312
social problem-solving training: 157-158
social resources: 374
social skills: 151-170
  assumptions: 155
  responsive classroom: 162-165
  teaching: 162-165
  training: 155-162
social status: 304
social stigma, suicide: 555
socially supportive learning environments: 151-170
  social skills and: 154
socioeconomic factors, trauma and: 316
socioemotional development grief and: 320-322
special needs youths
  ICPS: 121-123
  sudden death: 450-451
special relationship doctrine: 99-100
specific symptoms, treatment: 689-692
speech, regulation: 718-719
staff. *See* school, personnel
statistics: 95
  suicide: 211
Stockton, CA: 385
strengths, assessment: 29-30
students
  caring majority: 178
  handbook: 54
  initial tracking: 410-411
  knowing: 410
  support and involvement: 59-60
sudden events: 7
suicide: xv, 252, 724-726, 792
  culture and ethnicity: 537-538, 557
  developmental factors: 536-537, 556
  grief and: 654-655
  intervention: 538-551, 557-558
  model: 540, 543, 546-547
  legal issues: 535
  postvention: 553-576
  checklist: 576
  issues: 554-555
  precipitants: 214
  prevention: 211-223, 735-737
  protective factors: 214
  response programs: 215-220
  risk assessment
    referral data: 541-542
    student interview: 544-545
  risk factors: 213, 533-535
  sexual orientation: 537-538
  warning signs: 532-533
supervision, violence prevention: 238-239
support services, sudden death: 461
support systems, grief and: 656
support team, refugees: 606
Surgeon General's Call to Action to Prevent Suicide: 736

suspension: 716-717
symbolic behavior, changes and: 416-417
target: 758-759
task force: 340
teachers: 496
  GCI and: 389
  individual intervention: 407-408, 410
  social skills: 162-165
  sudden death: 458-460, 471
  suicide: 561, 565, 567
  training provided by, ICPS: 116-117, 119-120
  treatment: 422
  see also school, personnel
team-building: 27-28
teams: 5, 24-25
teenagers, child maltreatment: 511-512
terrorism: 334
theory: 5-46
threat
  assessment protocol: 61
  perceived: 370-371
  to others: 722-724
  to self: 724-726
time frames: 761
timeline: 28
timing: 774
tornadoes: 435
training
  bully prevention: 176-177
  curriculum: 339
  ICPS: 113-123
  peer mediators: 196-197
  programs: 62
  refugees: 606-607
  social skills: 155-162
  violence prevention: 238-239
transgeneration stage: 603-604
transition crisis group counseling, refugees: 609-610
trauma
  culture and: 297-298
  -focused coping: 686-687
  -focused therapy: 679-680
  history: 376-377
  implications: 337
  reenactment: 689-690
  unresolved, possible results: 406
traumatized youth, approaching: 413, 415
treatment: 419-424
  cognitive behavioral therapy: 684-687
  duration: 677
  fidelity: 762
  future: 692-694
  innovative: 675-704
  location: 677
  long-term: 15
  method: 676
  modality: 677-678
  multimodal treatment methods: 687-689
  specific symptoms: 689-692
trends: 47-48
triage: 415-418, 493-494
troubled youth: 60-61
  defined: 250
  identifying: 249-271
U.S. Secret Service threat-assessment model: 255-256, 257, 261
unexpected events: 7
uniqueness: 87-88
universality, death: 318
variables
  event: 356-360
  individual: 368-371
  vulnerability: 371-378
victims: 172, 173, 181-182
  relationship to: 369-370
Vietnamese students, sudden death: 454-455
violence: 49-53, 251-252, 487-502, 792-793
  definition: 758-759
  experience with: 489-490
  predictors of: 109-110
  prevalence: 48-49
  prevention: 104
  reactions to: 490-491

805

  research barriers: 758-763
  responses: 194
  risk: 256, 259
visitor screening: 56
vulnerability
  factors that create: 409
  variables: 371-378
war: 577-598
  cultural issues: 581
  developmental issues: 581
  intervention: 582-593
warning signs: 36-37, 41
  suicide: 532-533
weapons: 54-55, 56-57
writing, expressive, refugees: 609
zero tolerance: 743-744

"We are made strong by what we overcome." John Burrough

As little as a decade ago, crisis prevention and intervention were peripheral concerns—if they were concerns at all—for most American schools. Today, these issues are a primary responsibility of every school district in the country. We have come to realize that our children and youth are not immune to the impact of either daily stress or larger destructive forces that mark the beginning of the new millennium.

Although schools are among the safest places for children and youth, today educators deal with problems virtually unheard of in previous generations, such as school shootings and terrorism. They must be prepared to respond to any tragedy that affects the life of a school community, on or off campus. On-going prevention and intervention must underpin any effective crisis plan, with trained crisis teams actively engaged in both aspects.

Best Practices in School Crisis Prevention and Intervention offers educators, mental health professionals, and relevant community service providers the latest in theory and practice across the spectrum of issues involved in crisis prevention and response. Leading national and international experts contributed to 37 chapters that look at specific types of crises, individual and school-wide interventions, and long-term supports to help children heal. The first seminal work on the topic, this book provides:

- A foundation for developing comprehensive school crisis prevention and intervention teams
- Detailed information about crisis theory and the characteristics of responsive schools
- Guidance on implementing research-based practices that promote safe schools

An invaluable resource for school psychologists, school counselors, teachers, administrators, professors, clinical psychologists, and social workers—anyone working to keep young people safe.

"I am struck by the breadth of the subject matter, the effective blend of theory and practical application, the magnitude of world class expertise reflected in these pages." —*Rear Admiral Brian W. Flynn, Assistant Surgeon General, United States Public Health Service*

Stephen E. Brock [illegible] *at California* [illegible] *author* [illegible] **Philip J. Lazarus** *is* [illegible] *the School Psychology Program, Florida International University* [illegible] *and Chairperson of the NASP National Emergency Assistance Team; and* **Shane R. Jimerson** *is Assistant Professor at the University of California, Santa Barbara* [illegible]

NATIONAL
ASSOCIATION OF SCHOOL
PSYCHOLOGISTS

NASP

ISBN 0-932955-84-